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**H. R. 2563**

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IN THE SENATE OF THE UNITED STATES

SEPTEMBER 5, 2001

Received and read the first time

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Read the second time and placed on the calendar

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**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,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “Bipartisan Patient Protection Act”.

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

Sec. 1. Short title; table of contents.

**TITLE I—IMPROVING MANAGED CARE**

**Subtitle A—Utilization Review; Claims; and Internal and External Appeals**

- Sec. 101. Utilization review activities.
- Sec. 102. Procedures for initial claims for benefits and prior authorization determinations.
- Sec. 103. Internal appeals of claims denials.
- Sec. 104. Independent external appeals procedures.
- Sec. 105. Health care consumer assistance fund.

**Subtitle B—Access to Care**

- Sec. 111. Consumer choice option.
- Sec. 112. Choice of health care professional.
- Sec. 113. Access to emergency care.
- Sec. 114. Timely access to specialists.
- Sec. 115. Patient access to obstetrical and gynecological care.
- Sec. 116. Access to pediatric care.
- Sec. 117. Continuity of care.
- Sec. 118. Access to needed prescription drugs.
- Sec. 119. Coverage for individuals participating in approved clinical trials.
- Sec. 120. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.

**Subtitle C—Access to Information**

- Sec. 121. Patient access to information.

**Subtitle D—Protecting the Doctor-Patient Relationship**

- Sec. 131. Prohibition of interference with certain medical communications.
- Sec. 132. Prohibition of discrimination against providers based on licensure.
- Sec. 133. Prohibition against improper incentive arrangements.
- Sec. 134. Payment of claims.
- Sec. 135. Protection for patient advocacy.

**Subtitle E—Definitions**

- Sec. 151. Definitions.
- Sec. 152. Preemption; State flexibility; construction.
- Sec. 153. Exclusions.
- Sec. 154. Treatment of excepted benefits.
- Sec. 155. Regulations.

- Sec. 156. Incorporation into plan or coverage documents.
- Sec. 157. Preservation of protections.

## TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

- Sec. 201. Application to group health plans and group health insurance coverage.
- Sec. 202. Application to individual health insurance coverage.
- Sec. 203. Cooperation between Federal and State authorities.

## TITLE III—APPLICATION OF PATIENT PROTECTION STANDARDS TO FEDERAL HEALTH INSURANCE PROGRAMS

- Sec. 301. Application of patient protection standards to Federal health insurance programs.

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

### Subtitle A—General Provisions

- Sec. 401. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
- Sec. 402. Availability of civil remedies.
- Sec. 403. Limitation on certain class action litigation.
- Sec. 404. Limitations on actions.
- Sec. 405. Cooperation between Federal and State authorities.
- Sec. 406. Sense of the Senate concerning the importance of certain unpaid services.

### Subtitle B—Association Health Plans

- Sec. 421. Rules governing association health plans.
- Sec. 422. Clarification of treatment of single employer arrangements.
- Sec. 423. Clarification of treatment of certain collectively bargained arrangements.
- Sec. 424. Enforcement provisions relating to association health plans.
- Sec. 425. Cooperation between Federal and State authorities.
- Sec. 426. Effective date and transitional and other rules.

## TITLE V—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

### Subtitle A—Application of Patient Protection Provisions

- Sec. 501. Application to group health plans under the Internal Revenue Code of 1986.
- Sec. 502. Conforming enforcement for women’s health and cancer rights.

### Subtitle B—Health Care Coverage Access Tax Incentives

- Sec. 511. Expansion of availability of Archer medical savings accounts.
- Sec. 512. Deduction for 100 percent of health insurance costs of self-employed individuals.
- Sec. 513. Credit for health insurance expenses of small businesses.

- Sec. 514. Certain grants by private foundations to qualified health benefit purchasing coalitions.
- Sec. 515. State grant program for market innovation.

#### TITLE VI—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

- Sec. 601. Effective dates.
- Sec. 602. Coordination in implementation.
- Sec. 603. Severability.

#### TITLE VII—MISCELLANEOUS PROVISIONS

- Sec. 701. No impact on social security trust funds.
- Sec. 702. Customs user fees.
- Sec. 703. Fiscal year 2002 medicare payments.
- Sec. 704. Sense of the Senate with respect to participation in clinical trials and access to specialty care.
- Sec. 705. Sense of the Senate regarding fair review process.
- Sec. 706. Annual review.
- Sec. 707. Definition of born-alive infant.

## 1 **TITLE I—IMPROVING MANAGED**

## 2 **CARE**

### 3 **Subtitle A—Utilization Review;**

### 4 **Claims; and Internal and Exter-**

### 5 **nal Appeals**

#### 6 **SEC. 101. UTILIZATION REVIEW ACTIVITIES.**

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

8 (1) IN GENERAL.—A group health plan, and a

9 health insurance issuer that provides health insur-

10 ance coverage, shall conduct utilization review activi-

11 ties in connection with the provision of benefits

12 under such plan or coverage only in accordance with

13 a utilization review program that meets the require-

14 ments of this section and section 503A of the Em-

15 ployee Retirement Income Security Act of 1974.

1           (2) USE OF OUTSIDE AGENTS.—Nothing in this  
2       section shall be construed as preventing a group  
3       health plan or health insurance issuer from arrang-  
4       ing through a contract or otherwise for persons or  
5       entities to conduct utilization review activities on be-  
6       half of the plan or issuer, so long as such activities  
7       are conducted in accordance with a utilization review  
8       program that meets the requirements of this section.

9           (3) UTILIZATION REVIEW DEFINED.—For pur-  
10      poses of this section, the terms “utilization review”  
11      and “utilization review activities” mean procedures  
12      used to monitor or evaluate the use or coverage,  
13      clinical necessity, appropriateness, efficacy, or effi-  
14      ciency of health care services, procedures or settings,  
15      and includes prospective review, concurrent review,  
16      second opinions, case management, discharge plan-  
17      ning, or retrospective review.

18      (b) WRITTEN POLICIES AND CRITERIA.—

19           (1) WRITTEN POLICIES.—A utilization review  
20      program shall be conducted consistent with written  
21      policies and procedures that govern all aspects of the  
22      program.

23           (2) USE OF WRITTEN CRITERIA.—

24           (A) IN GENERAL.—Such a program shall  
25      utilize written clinical review criteria developed

1 with input from a range of appropriate actively  
2 practicing health care professionals, as deter-  
3 mined by the plan, pursuant to the program.  
4 Such criteria shall include written clinical re-  
5 view criteria that are based on valid clinical evi-  
6 dence where available and that are directed spe-  
7 cifically at meeting the needs of at-risk popu-  
8 lations and covered individuals with chronic  
9 conditions or severe illnesses, including gender-  
10 specific criteria and pediatric-specific criteria  
11 where available and appropriate.

12 (B) CONTINUING USE OF STANDARDS IN  
13 RETROSPECTIVE REVIEW.—If a health care  
14 service has been specifically pre-authorized or  
15 approved for a participant, beneficiary, or en-  
16 rollee under such a program, the program shall  
17 not, pursuant to retrospective review, revise or  
18 modify the specific standards, criteria, or proce-  
19 dures used for the utilization review for proce-  
20 dures, treatment, and services delivered to the  
21 enrollee during the same course of treatment.

22 (C) REVIEW OF SAMPLE OF CLAIMS DENI-  
23 ALS.—Such a program shall provide for a peri-  
24 odic evaluation of the clinical appropriateness of

1 at least a sample of denials of claims for bene-  
2 fits.

3 (c) CONDUCT OF PROGRAM ACTIVITIES.—

4 (1) ADMINISTRATION BY HEALTH CARE PRO-  
5 FESSIONALS.—A utilization review program shall be  
6 administered by qualified health care professionals  
7 who shall oversee review decisions.

8 (2) USE OF QUALIFIED, INDEPENDENT PER-  
9 SONNEL.—

10 (A) IN GENERAL.—A utilization review  
11 program shall provide for the conduct of utiliza-  
12 tion review activities only through personnel  
13 who are qualified and have received appropriate  
14 training in the conduct of such activities under  
15 the program.

16 (B) PROHIBITION OF CONTINGENT COM-  
17 PENSATION ARRANGEMENTS.—Such a program  
18 shall not, with respect to utilization review ac-  
19 tivities, permit or provide compensation or any-  
20 thing of value to its employees, agents, or con-  
21 tractors in a manner that encourages denials of  
22 claims for benefits.

23 (C) PROHIBITION OF CONFLICTS.—Such a  
24 program shall not permit a health care profes-  
25 sional who is providing health care services to

1 an individual to perform utilization review ac-  
2 tivities in connection with the health care serv-  
3 ices being provided to the individual.

4 (3) ACCESSIBILITY OF REVIEW.—Such a pro-  
5 gram shall provide that appropriate personnel per-  
6 forming utilization review activities under the pro-  
7 gram, including the utilization review administrator,  
8 are reasonably accessible by toll-free telephone dur-  
9 ing normal business hours to discuss patient care  
10 and allow response to telephone requests, and that  
11 appropriate provision is made to receive and respond  
12 promptly to calls received during other hours.

13 (4) LIMITS ON FREQUENCY.—Such a program  
14 shall not provide for the performance of utilization  
15 review activities with respect to a class of services  
16 furnished to an individual more frequently than is  
17 reasonably required to assess whether the services  
18 under review are medically necessary and appro-  
19 priate.

20 **SEC. 102. PROCEDURES FOR INITIAL CLAIMS FOR BENE-**  
21 **FITS AND PRIOR AUTHORIZATION DETER-**  
22 **MINATIONS.**

23 Part 5 of subtitle B of title I of the Employee Retire-  
24 ment Income Security Act of 1974 is amended by insert-  
25 ing after section 503 (29 U.S.C. 1133) the following:



1 **“SEC. 503A. PROCEDURES FOR INITIAL CLAIMS FOR BENE-**  
2 **FITS AND PRIOR AUTHORIZATION DETER-**  
3 **MINATIONS.**

4 “(a) PROCEDURES OF INITIAL CLAIMS FOR BENE-  
5 FITS.—

6 “(1) IN GENERAL.—A group health plan, and a  
7 health insurance issuer offering health insurance  
8 coverage in connection with the group health plan,  
9 shall—

10 “(A) make a determination on an initial  
11 claim for benefits by a participant or bene-  
12 ficiary (or authorized representative) regarding  
13 payment or coverage for items or services under  
14 the terms and conditions of the plan or cov-  
15 erage involved, including any cost-sharing  
16 amount that the participant or beneficiary is re-  
17 quired to pay with respect to such claim for  
18 benefits; and

19 “(B) notify a participant or beneficiary (or  
20 authorized representative) and the treating  
21 health care professional involved regarding a  
22 determination on an initial claim for benefits  
23 made under the terms and conditions of the  
24 plan or coverage, including any cost-sharing  
25 amounts that the participant or beneficiary may  
26 be required to make with respect to such claim

1 for benefits, and of the right of the participant  
2 or beneficiary to an internal appeal under sec-  
3 tion 503B.

4 “(2) ACCESS TO INFORMATION.—

5 “(A) TIMELY PROVISION OF NECESSARY  
6 INFORMATION.—With respect to an initial claim  
7 for benefits, the participant or beneficiary (or  
8 authorized representative) and the treating  
9 health care professional (if any) shall provide  
10 the plan or issuer with access to information re-  
11 quested by the plan or issuer that is necessary  
12 to make a determination relating to the claim.  
13 Such access shall be provided not later than 5  
14 days after the date on which the request for in-  
15 formation is received, or, in a case described in  
16 subparagraph (B) or (C) of subsection (b)(1),  
17 by such earlier time as may be necessary to  
18 comply with the applicable timeline under such  
19 subparagraph.

20 “(B) LIMITED EFFECT OF FAILURE ON  
21 PLAN OR ISSUER’S OBLIGATIONS.—Failure of  
22 the participant or beneficiary to comply with  
23 the requirements of subparagraph (A) shall not  
24 remove the obligation of the plan or issuer to  
25 make a decision in accordance with the medical

1 exigencies of the case and as soon as possible,  
2 based on the available information, and failure  
3 to comply with the time limit established by this  
4 paragraph shall not remove the obligation of  
5 the plan or issuer to comply with the require-  
6 ments of this section.

7 “(3) ORAL REQUESTS.—In the case of a claim  
8 for benefits involving an expedited or concurrent de-  
9 termination, a participant or beneficiary (or author-  
10 ized representative) may make an initial claim for  
11 benefits orally, but a group health plan, or health in-  
12 surance issuer offering health insurance coverage in  
13 connection with the group health plan, may require  
14 that the participant or beneficiary (or authorized  
15 representative) provide written confirmation of such  
16 request in a timely manner on a form provided by  
17 the plan or issuer. In the case of such an oral re-  
18 quest for benefits, the making of the request (and  
19 the timing of such request) shall be treated as the  
20 making at that time of a claim for such benefits  
21 without regard to whether and when a written con-  
22 firmation of such request is made.

23 “(b) TIMELINE FOR MAKING DETERMINATIONS.—

24 “(1) PRIOR AUTHORIZATION DETERMINA-  
25 TION.—

1           “(A) IN GENERAL.—A group health plan,  
2           and a health insurance issuer offering health in-  
3           surance coverage in connection with the group  
4           health plan, shall make a prior authorization  
5           determination on a claim for benefits (whether  
6           oral or written) in accordance with the medical  
7           exigencies of the case and as soon as possible,  
8           but in no case later than 14 days from the date  
9           on which the plan or issuer receives information  
10          that is reasonably necessary to enable the plan  
11          or issuer to make a determination on the re-  
12          quest for prior authorization and in no case  
13          later than 28 days after the date of the claim  
14          for benefits is received.

15          “(B) EXPEDITED DETERMINATION.—Not-  
16          withstanding subparagraph (A), a group health  
17          plan, and a health insurance issuer offering  
18          health insurance coverage in connection with  
19          the group health plan, shall expedite a prior au-  
20          thorization determination on a claim for bene-  
21          fits described in such subparagraph when a re-  
22          quest for such an expedited determination is  
23          made by a participant or beneficiary (or author-  
24          ized representative) at any time during the  
25          process for making a determination and a

1 health care professional certifies, with the re-  
2 quest, that a determination under the proce-  
3 dures described in subparagraph (A) would seri-  
4 ously jeopardize the life or health of the partici-  
5 pant or beneficiary or the ability of the partici-  
6 pant or beneficiary to maintain or regain max-  
7 imum function. Such determination shall be  
8 made in accordance with the medical exigencies  
9 of the case and as soon as possible, but in no  
10 case later than 72 hours after the time the re-  
11 quest is received by the plan or issuer under  
12 this subparagraph.

13 “(C) ONGOING CARE.—

14 “(i) CONCURRENT REVIEW.—

15 “(I) IN GENERAL.—Subject to  
16 clause (ii), in the case of a concurrent  
17 review of ongoing care (including hos-  
18 pitalization), which results in a termi-  
19 nation or reduction of such care, the  
20 plan or issuer must provide by tele-  
21 phone and in printed form notice of  
22 the concurrent review determination  
23 to the individual or the individual’s  
24 designee and the individual’s health  
25 care provider in accordance with the

1 medical exigencies of the case and as  
2 soon as possible, with sufficient time  
3 prior to the termination or reduction  
4 to allow for an appeal under section  
5 503B(b)(3) to be completed before the  
6 termination or reduction takes effect.

7 “(II) CONTENTS OF NOTICE.—

8 Such notice shall include, with respect  
9 to ongoing health care items and serv-  
10 ices, the number of ongoing services  
11 approved, the new total of approved  
12 services, the date of onset of services,  
13 and the next review date, if any, as  
14 well as a statement of the individual’s  
15 rights to further appeal.

16 “(ii) RULE OF CONSTRUCTION.—

17 Clause (i) shall not be construed as requir-  
18 ing plans or issuers to provide coverage of  
19 care that would exceed the coverage limita-  
20 tions for such care.

21 “(2) RETROSPECTIVE DETERMINATION.—A

22 group health plan, and a health insurance issuer of-  
23 fering health insurance coverage in connection with  
24 the group health plan, shall make a retrospective de-  
25 termination on a claim for benefits in accordance

1 with the medical exigencies of the case and as soon  
2 as possible, but not later than 30 days after the date  
3 on which the plan or issuer receives information that  
4 is reasonably necessary to enable the plan or issuer  
5 to make a determination on the claim, or, if earlier,  
6 60 days after the date of receipt of the claim for  
7 benefits.

8 “(c) NOTICE OF A DENIAL OF A CLAIM FOR BENE-  
9 FITS.—Written notice of a denial made under an initial  
10 claim for benefits shall be issued to the participant or ben-  
11 eficiary (or authorized representative) and the treating  
12 health care professional in accordance with the medical ex-  
13 igencies of the case and as soon as possible, but in no  
14 case later than 2 days after the date of the determination  
15 (or, in the case described in subparagraph (B) or (C) of  
16 subsection (b)(1), within the 72-hour or applicable period  
17 referred to in such subparagraph).

18 “(d) REQUIREMENTS OF NOTICE OF DETERMINA-  
19 TIONS.—The written notice of a denial of a claim for bene-  
20 fits determination under subsection (c) shall be provided  
21 in printed form and written in a manner calculated to be  
22 understood by the participant or beneficiary and shall  
23 include—

1 “(1) the specific reasons for the determination  
2 (including a summary of the clinical or scientific evi-  
3 dence used in making the determination);

4 “(2) the procedures for obtaining additional in-  
5 formation concerning the determination; and

6 “(3) notification of the right to appeal the de-  
7 termination and instructions on how to initiate an  
8 appeal in accordance with section 503B.

9 “(e) DEFINITIONS.—For purposes of this section and  
10 sections 503B and 503C:

11 “(1) AUTHORIZED REPRESENTATIVE.—The  
12 term ‘authorized representative’ means, with respect  
13 to an individual who is a participant or beneficiary,  
14 any health care professional or other person acting  
15 on behalf of the individual with the individual’s con-  
16 sent or without such consent if the individual is  
17 medically unable to provide such consent.

18 “(2) CLAIM FOR BENEFITS.—The term ‘claim  
19 for benefits’ means any request for coverage (includ-  
20 ing authorization of coverage), for eligibility, or for  
21 payment in whole or in part, for an item or service  
22 under a group health plan or health insurance cov-  
23 erage in connection with the group health plan.

24 “(3) DENIAL OF CLAIM FOR BENEFITS.—The  
25 term ‘denial’ means, with respect to a claim for ben-



1       efits, a denial (in whole or in part) of, or a failure  
 2       to act in accordance with the applicable deadlines es-  
 3       tablished under this section and section 503B upon,  
 4       the claim for benefits and includes a failure to pro-  
 5       vide benefits (including items and services) required  
 6       to be provided under title I of the Bipartisan Patient  
 7       Protection Act.

8           “(4) TREATING HEALTH CARE PROFES-  
 9       SIONAL.—The term ‘treating health care profes-  
 10      sional’ means, with respect to services to be provided  
 11      to a participant or beneficiary, a health care profes-  
 12      sional who is primarily responsible for delivering  
 13      those services to the participant or beneficiary.

14          “(5) OTHER DEFINITIONS.—Section 151 of the  
 15      Bipartisan Patient Protection Act shall apply.”.

16 **SEC. 103. INTERNAL APPEALS OF CLAIMS DENIALS.**

17       Part 5 of subtitle B of title I of the Employee Retire-  
 18      ment Income Security Act of 1974 (as amended by section  
 19      503A) is amended further by inserting after section 503A  
 20      (29 U.S.C. 1133A) the following:

21 **“SEC. 503B. INTERNAL APPEALS OF CLAIMS DENIALS.**

22       “(a) RIGHT TO INTERNAL APPEAL.—

23           “(1) IN GENERAL.—A participant or beneficiary  
 24      (or authorized representative) may appeal any denial

1 of a claim for benefits under section 503A under the  
2 procedures described in this section.

3 “(2) TIME FOR APPEAL.—

4 “(A) IN GENERAL.—A group health plan,  
5 and a health insurance issuer offering health in-  
6 surance coverage in connection with the group  
7 health plan, shall ensure that a participant or  
8 beneficiary (or authorized representative) has a  
9 period of not less than 180 days beginning on  
10 the date of a denial of a claim for benefits  
11 under section 503A in which to appeal such de-  
12 nial under this section.

13 “(B) DATE OF DENIAL.—For purposes of  
14 subparagraph (A), the date of the denial shall  
15 be deemed to be the date as of which the partic-  
16 ipant or beneficiary knew of the denial of the  
17 claim for benefits.

18 “(3) FAILURE TO ACT.—The failure of a plan  
19 or issuer to issue a determination on a claim for  
20 benefits under section 503A within the applicable  
21 timeline established for such a determination under  
22 such section is a denial of a claim for benefits for  
23 purposes this section and sections 503B and 503C  
24 as of the date of the applicable deadline.

1           “(4) PLAN WAIVER OF INTERNAL REVIEW.—A  
2       group health plan, or health insurance issuer offer-  
3       ing health insurance coverage in connection with the  
4       group health plan, may waive the internal review  
5       process under this section. In such case the plan or  
6       issuer shall provide notice to the participant or bene-  
7       ficiary (or authorized representative) involved, the  
8       participant or beneficiary (or authorized representa-  
9       tive) involved shall be relieved of any obligation to  
10      complete the internal review involved, and may, at  
11      the option of such participant, beneficiary, or rep-  
12      resentative proceed directly to seek further appeal  
13      through external review under section 503C or oth-  
14      erwise.

15      “(b) TIMELINES FOR MAKING DETERMINATIONS.—

16           “(1) ORAL REQUESTS.—In the case of an ap-  
17      peal of a denial of a claim for benefits under this  
18      section that involves an expedited or concurrent de-  
19      termination, a participant or beneficiary (or author-  
20      ized representative) may request such appeal orally.  
21      A group health plan, or health insurance issuer of-  
22      fering health insurance coverage in connection with  
23      the group health plan, may require that the partici-  
24      pant or beneficiary (or authorized representative)  
25      provide written confirmation of such request in a

1       timely manner on a form provided by the plan or  
2       issuer. In the case of such an oral request for an ap-  
3       peal of a denial, the making of the request (and the  
4       timing of such request) shall be treated as the mak-  
5       ing at that time of a request for an appeal without  
6       regard to whether and when a written confirmation  
7       of such request is made.

8               “(2) ACCESS TO INFORMATION.—

9               “(A) TIMELY PROVISION OF NECESSARY  
10              INFORMATION.—With respect to an appeal of a  
11              denial of a claim for benefits, the participant or  
12              beneficiary (or authorized representative) and  
13              the treating health care professional (if any)  
14              shall provide the plan or issuer with access to  
15              information requested by the plan or issuer that  
16              is necessary to make a determination relating to  
17              the appeal. Such access shall be provided not  
18              later than 5 days after the date on which the  
19              request for information is received, or, in a case  
20              described in subparagraph (B) or (C) of para-  
21              graph (3), by such earlier time as may be nec-  
22              essary to comply with the applicable timeline  
23              under such subparagraph.

24              “(B) LIMITED EFFECT OF FAILURE ON  
25              PLAN OR ISSUER’S OBLIGATIONS.—Failure of

1 the participant or beneficiary to comply with  
2 the requirements of subparagraph (A) shall not  
3 remove the obligation of the plan or issuer to  
4 make a decision in accordance with the medical  
5 exigencies of the case and as soon as possible,  
6 based on the available information, and failure  
7 to comply with the time limit established by this  
8 paragraph shall not remove the obligation of  
9 the plan or issuer to comply with the require-  
10 ments of this section.

11 “(3) PRIOR AUTHORIZATION DETERMINA-  
12 TIONS.—

13 “(A) IN GENERAL.—Except as provided in  
14 this paragraph or paragraph (4), a group  
15 health plan, and a health insurance issuer offer-  
16 ing health insurance coverage in connection  
17 with the group health plan, shall make a deter-  
18 mination on an appeal of a denial of a claim for  
19 benefits under this subsection in accordance  
20 with the medical exigencies of the case and as  
21 soon as possible, but in no case later than 14  
22 days from the date on which the plan or issuer  
23 receives information that is reasonably nec-  
24 essary to enable the plan or issuer to make a  
25 determination on the appeal and in no case

1 later than 28 days after the date the request  
2 for the appeal is received.

3 “(B) EXPEDITED DETERMINATION.—Not-  
4 withstanding subparagraph (A), a group health  
5 plan, and a health insurance issuer offering  
6 health insurance coverage in connection with  
7 the group health plan, shall expedite a prior au-  
8 thorization determination on an appeal of a de-  
9 nial of a claim for benefits described in sub-  
10 paragraph (A), when a request for such an ex-  
11 pedited determination is made by a participant  
12 or beneficiary (or authorized representative) at  
13 any time during the process for making a deter-  
14 mination and a health care professional cer-  
15 tifies, with the request, that a determination  
16 under the procedures described in subparagraph  
17 (A) would seriously jeopardize the life or health  
18 of the participant or beneficiary or the ability of  
19 the participant or beneficiary to maintain or re-  
20 gain maximum function. Such determination  
21 shall be made in accordance with the medical  
22 exigencies of the case and as soon as possible,  
23 but in no case later than 72 hours after the  
24 time the request for such appeal is received by  
25 the plan or issuer under this subparagraph.

1 “(C) ONGOING CARE DETERMINATIONS.—

2 “(i) IN GENERAL.—Subject to clause  
3 (ii), in the case of a concurrent review de-  
4 termination described in section  
5 503A(b)(1)(C)(i)(I), which results in a ter-  
6 mination or reduction of such care, the  
7 plan or issuer must provide notice of the  
8 determination on the appeal under this  
9 section by telephone and in printed form to  
10 the individual or the individual’s designee  
11 and the individual’s health care provider in  
12 accordance with the medical exigencies of  
13 the case and as soon as possible, with suf-  
14 ficient time prior to the termination or re-  
15 duction to allow for an external appeal  
16 under section 503C to be completed before  
17 the termination or reduction takes effect.

18 “(ii) RULE OF CONSTRUCTION.—  
19 Clause (i) shall not be construed as requir-  
20 ing plans or issuers to provide coverage of  
21 care that would exceed the coverage limita-  
22 tions for such care.

23 “(4) RETROSPECTIVE DETERMINATION.—A  
24 group health plan, and a health insurance issuer of-  
25 fering health insurance coverage in connection with

1 the group health plan, shall make a retrospective de-  
2 termination on an appeal of a denial of a claim for  
3 benefits in no case later than 30 days after the date  
4 on which the plan or issuer receives necessary infor-  
5 mation that is reasonably necessary to enable the  
6 plan or issuer to make a determination on the ap-  
7 peal and in no case later than 60 days after the date  
8 the request for the appeal is received.

9 “(c) CONDUCT OF REVIEW.—

10 “(1) IN GENERAL.—A review of a denial of a  
11 claim for benefits under this section shall be con-  
12 ducted by an individual with appropriate expertise  
13 who was not involved in the initial determination.

14 “(2) PEER REVIEW OF MEDICAL DECISIONS BY  
15 HEALTH CARE PROFESSIONALS.—A review of an ap-  
16 peal of a denial of a claim for benefits that is based  
17 on a lack of medical necessity and appropriateness,  
18 or based on an experimental or investigational treat-  
19 ment, or requires an evaluation of medical facts—

20 “(A) shall be made by a physician  
21 (allopathic or osteopathic); or

22 “(B) in a claim for benefits provided by a  
23 non-physician health professional, shall be made  
24 by a review panel including at least one prac-



1           ting non-physician health professional of the  
2           same or similar specialty,  
3           with appropriate expertise (including, in the case of  
4           a child, appropriate pediatric expertise) and acting  
5           within the appropriate scope of practice within the  
6           State in which the service is provided or rendered,  
7           who was not involved in the initial determination.

8           “(d) NOTICE OF DETERMINATION.—

9           “(1) IN GENERAL.—Written notice of a deter-  
10          mination made under an internal appeal of a denial  
11          of a claim for benefits shall be issued to the partici-  
12          pant or beneficiary (or authorized representative)  
13          and the treating health care professional in accord-  
14          ance with the medical exigencies of the case and as  
15          soon as possible, but in no case later than 2 days  
16          after the date of completion of the review (or, in the  
17          case described in subparagraph (B) or (C) of sub-  
18          section (b)(3), within the 72-hour or applicable pe-  
19          riod referred to in such subparagraph).

20          “(2) FINAL DETERMINATION.—The decision by  
21          a plan or issuer under this section shall be treated  
22          as the final determination of the plan or issuer on  
23          a denial of a claim for benefits. The failure of a plan  
24          or issuer to issue a determination on an appeal of  
25          a denial of a claim for benefits under this section

1 within the applicable timeline established for such a  
 2 determination shall be treated as a final determina-  
 3 tion on an appeal of a denial of a claim for benefits  
 4 for purposes of proceeding to external review under  
 5 section 503C.

6 “(3) REQUIREMENTS OF NOTICE.—With re-  
 7 spect to a determination made under this section,  
 8 the notice described in paragraph (1) shall be pro-  
 9 vided in printed form and written in a manner cal-  
 10 culated to be understood by the participant or bene-  
 11 ficiary and shall include—

12 “(A) the specific reasons for the deter-  
 13 mination (including a summary of the clinical  
 14 or scientific evidence used in making the deter-  
 15 mination);

16 “(B) the procedures for obtaining addi-  
 17 tional information concerning the determina-  
 18 tion; and

19 “(C) notification of the right to an inde-  
 20 pendent external review under section 503C and  
 21 instructions on how to initiate such a review.”.

22 **SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCE-**  
 23 **DURES.**

24 (a) IN GENERAL.—Part 5 of subtitle B of title I of  
 25 the Employee Retirement Income Security Act of 1974 (as

1 amended by sections 503A and 503B) is amended further  
2 by inserting after section 503B (29 U.S.C. 1133B) the  
3 following:

4 **“SEC. 503C. INDEPENDENT EXTERNAL APPEALS PROCE-**  
5 **DURES.**

6 “(a) RIGHT TO EXTERNAL APPEAL.—A group health  
7 plan, and a health insurance issuer offering health insur-  
8 ance coverage in connection with the group health plan,  
9 shall provide in accordance with this section participants  
10 and beneficiaries (or authorized representatives) with ac-  
11 cess to an independent external review for any denial of  
12 a claim for benefits.

13 “(b) INITIATION OF THE INDEPENDENT EXTERNAL  
14 REVIEW PROCESS.—

15 “(1) TIME TO FILE.—A request for an inde-  
16 pendent external review under this section shall be  
17 filed with the plan or issuer not later than 180 days  
18 after the date on which the participant or bene-  
19 ficiary receives notice of the denial under section  
20 503B(d) or notice of waiver of internal review under  
21 section 503B(a)(4) or the date on which the plan or  
22 issuer has failed to make a timely decision under  
23 section 503B(d)(2) and notifies the participant or  
24 beneficiary that it has failed to make a timely deci-  
25 sion and that the beneficiary must file an appeal

1 with an external review entity within 180 days if the  
2 participant or beneficiary desires to file such an ap-  
3 peal.

4 “(2) FILING OF REQUEST.—

5 “(A) IN GENERAL.—Subject to the suc-  
6 ceeding provisions of this subsection, a group  
7 health plan, or health insurance issuer offering  
8 health insurance coverage in connection with  
9 the group health plan, may—

10 “(i) except as provided in subpara-  
11 graph (B)(i), require that a request for re-  
12 view be in writing;

13 “(ii) limit the filing of such a request  
14 to the participant or beneficiary involved  
15 (or an authorized representative);

16 “(iii) except if waived by the plan or  
17 issuer under section 503B(a)(4), condition  
18 access to an independent external review  
19 under this section upon a final determina-  
20 tion of a denial of a claim for benefits  
21 under the internal review procedure under  
22 section 503B;

23 “(iv) except as provided in subpara-  
24 graph (B)(ii), require payment of a filing

1 fee to the plan or issuer of a sum that does  
2 not exceed \$25; and

3 “(v) require that a request for review  
4 include the consent of the participant or  
5 beneficiary (or authorized representative)  
6 for the release of necessary medical infor-  
7 mation or records of the participant or  
8 beneficiary to the qualified external review  
9 entity only for purposes of conducting ex-  
10 ternal review activities.

11 “(B) REQUIREMENTS AND EXCEPTION RE-  
12 LATING TO GENERAL RULE.—

13 “(i) ORAL REQUESTS PERMITTED IN  
14 EXPEDITED OR CONCURRENT CASES.—In  
15 the case of an expedited or concurrent ex-  
16 ternal review as provided for under sub-  
17 section (e), the request for such review  
18 may be made orally. A group health plan,  
19 or health insurance issuer offering health  
20 insurance coverage in connection with the  
21 group health plan, may require that the  
22 participant or beneficiary (or authorized  
23 representative) provide written confirma-  
24 tion of such request in a timely manner on  
25 a form provided by the plan or issuer.

1           Such written confirmation shall be treated  
2           as a consent for purposes of subparagraph  
3           (A)(v). In the case of such an oral request  
4           for such a review, the making of the re-  
5           quest (and the timing of such request)  
6           shall be treated as the making at that time  
7           of a request for such a review without re-  
8           gard to whether and when a written con-  
9           firmation of such request is made.

10           “(ii) EXCEPTION TO FILING FEE RE-  
11           QUIREMENT.—

12                   “(I) INDIGENCY.—Payment of a  
13                   filing fee shall not be required under  
14                   subparagraph (A)(iv) where there is a  
15                   certification (in a form and manner  
16                   specified in guidelines established by  
17                   the appropriate Secretary) that the  
18                   participant or beneficiary is indigent  
19                   (as defined in such guidelines).

20                   “(II) FEE NOT REQUIRED.—Pay-  
21                   ment of a filing fee shall not be re-  
22                   quired under subparagraph (A)(iv) if  
23                   the plan or issuer waives the internal  
24                   appeals process under section  
25                   503B(a)(4).

1 “(III) REFUNDING OF FEE.—

2 The filing fee paid under subpara-  
3 graph (A)(iv) shall be refunded if the  
4 determination under the independent  
5 external review is to reverse the denial  
6 which is the subject of the review.

7 “(IV) COLLECTION OF FILING  
8 FEE.—The failure to pay such a filing  
9 fee shall not prevent the consideration  
10 of a request for review but, subject to  
11 the preceding provisions of this clause,  
12 shall constitute a legal liability to pay.

13 “(c) REFERRAL TO QUALIFIED EXTERNAL REVIEW  
14 ENTITY UPON REQUEST.—

15 “(1) IN GENERAL.—Upon the filing of a re-  
16 quest for independent external review with the group  
17 health plan, or health insurance issuer offering  
18 health insurance coverage in connection with the  
19 group health plan, the plan or issuer shall imme-  
20 diately refer such request, and forward the plan or  
21 issuer’s initial decision (including the information  
22 described in section 503B(d)(3)(A)), to a qualified  
23 external review entity selected in accordance with  
24 this section.

1           “(2) ACCESS TO PLAN OR ISSUER AND HEALTH  
2           PROFESSIONAL INFORMATION.—With respect to an  
3           independent external review conducted under this  
4           section, the participant or beneficiary (or authorized  
5           representative), the plan or issuer, and the treating  
6           health care professional (if any) shall provide the ex-  
7           ternal review entity with information that is nec-  
8           essary to conduct a review under this section, as de-  
9           termined and requested by the entity. Such informa-  
10          tion shall be provided not later than 5 days after the  
11          date on which the request for information is re-  
12          ceived, or, in a case described in clause (ii) or (iii)  
13          of subsection (e)(1)(A), by such earlier time as may  
14          be necessary to comply with the applicable timeline  
15          under such clause.

16           “(3) SCREENING OF REQUESTS BY QUALIFIED  
17          EXTERNAL REVIEW ENTITIES.—

18           “(A) IN GENERAL.—With respect to a re-  
19          quest referred to a qualified external review en-  
20          tity under paragraph (1) relating to a denial of  
21          a claim for benefits, the entity shall refer such  
22          request for the conduct of an independent med-  
23          ical review unless the entity determines that—



1 “(i) any of the conditions described in  
2 clauses (ii) or (iii) of subsection (b)(2)(A)  
3 have not been met;

4 “(ii) the denial of the claim for bene-  
5 fits does not involve a medically reviewable  
6 decision under subsection (d)(2);

7 “(iii) the denial of the claim for bene-  
8 fits relates to a decision regarding whether  
9 an individual is a participant or beneficiary  
10 who is enrolled under the terms and condi-  
11 tions of the plan or coverage (including the  
12 applicability of any waiting period under  
13 the plan or coverage); or

14 “(iv) the denial of the claim for bene-  
15 fits is a decision as to the application of  
16 cost-sharing requirements or the applica-  
17 tion of a specific exclusion or express limi-  
18 tation on the amount, duration, or scope of  
19 coverage of items or services under the  
20 terms and conditions of the plan or cov-  
21 erage unless the decision is a denial de-  
22 scribed in subsection (d)(2).

23 Upon making a determination that any of  
24 clauses (i) through (iv) applies with respect to  
25 the request, the entity shall determine that the

1 denial of a claim for benefits involved is not eli-  
2 gible for independent medical review under sub-  
3 section (d), and shall provide notice in accord-  
4 ance with subparagraph (C).

5 “(B) PROCESS FOR MAKING DETERMINA-  
6 TIONS.—

7 “(i) NO DEFERENCE TO PRIOR DE-  
8 TERMINATIONS.—In making determina-  
9 tions under subparagraph (A), there shall  
10 be no deference given to determinations  
11 made by the plan or issuer or the rec-  
12 ommendation of a treating health care pro-  
13 fessional (if any).

14 “(ii) USE OF APPROPRIATE PER-  
15 SONNEL.—A qualified external review enti-  
16 ty shall use appropriately qualified per-  
17 sonnel to make determinations under this  
18 section.

19 “(C) NOTICES AND GENERAL TIMELINES  
20 FOR DETERMINATION.—

21 “(i) NOTICE IN CASE OF DENIAL OF  
22 REFERRAL.—If the entity under this para-  
23 graph does not make a referral to an inde-  
24 pendent medical review panel, the entity  
25 shall provide notice to the plan or issuer,

1 the participant or beneficiary (or author-  
2 ized representative) filing the request, and  
3 the treating health care professional (if  
4 any) that the denial is not subject to inde-  
5 pendent medical review. Such notice—

6 “(I) shall be written (and, in ad-  
7 dition, may be provided orally) in a  
8 manner calculated to be understood  
9 by a participant;

10 “(II) shall include the reasons for  
11 the determination;

12 “(III) include any relevant terms  
13 and conditions of the plan or cov-  
14 erage; and

15 “(IV) include a description of  
16 any further recourse available to the  
17 individual.

18 “(ii) GENERAL TIMELINE FOR DETER-  
19 MINATIONS.—Upon receipt of information  
20 under paragraph (2), the qualified external  
21 review entity, and if required the inde-  
22 pendent medical review panel, shall make a  
23 determination within the overall timeline  
24 that is applicable to the case under review  
25 as described in subsection (e), except that

1 if the entity determines that a referral to  
2 an independent medical review panel is not  
3 required, the entity shall provide notice of  
4 such determination to the participant or  
5 beneficiary (or authorized representative)  
6 within such timeline and within 2 days of  
7 the date of such determination.

8 “(d) INDEPENDENT MEDICAL REVIEW.—

9 “(1) IN GENERAL.—If a qualified external re-  
10 view entity determines under subsection (c) that a  
11 denial of a claim for benefits is eligible for inde-  
12 pendent medical review, the entity shall refer the de-  
13 nial involved to an independent medical review panel  
14 composed of 3 independent medical reviewers for the  
15 conduct of an independent medical review under this  
16 subsection.

17 “(2) MEDICALLY REVIEWABLE DECISIONS.—A  
18 denial of a claim for benefits is eligible for inde-  
19 pendent medical review if the benefit for the item or  
20 service for which the claim is made would be a cov-  
21 ered benefit under the terms and conditions of the  
22 plan or coverage but for one (or more) of the fol-  
23 lowing determinations:

24 “(A) DENIALS BASED ON MEDICAL NECES-  
25 SITY AND APPROPRIATENESS.—A determination

1           that the item or service is not covered because  
2           it is not medically necessary and appropriate or  
3           based on the application of substantially equiva-  
4           lent terms.

5           “(B) DENIALS BASED ON EXPERIMENTAL  
6           OR INVESTIGATIONAL TREATMENT.—A deter-  
7           mination that the item or service is not covered  
8           because it is experimental or investigational or  
9           based on the application of substantially equiva-  
10          lent terms.

11          “(C) DENIALS OTHERWISE BASED ON AN  
12          EVALUATION OF MEDICAL FACTS.—A deter-  
13          mination that the item or service or condition  
14          is not covered based on grounds that require an  
15          evaluation of the medical facts by a health care  
16          professional in the specific case involved to de-  
17          termine the coverage and extent of coverage of  
18          the item or service or condition.

19          “(3) INDEPENDENT MEDICAL REVIEW DETER-  
20          MINATION.—

21                 “(A) IN GENERAL.—An independent med-  
22                 ical review panel under this section shall make  
23                 a new independent determination with respect  
24                 to whether or not the denial of a claim for a

1 benefit that is the subject of the review should  
2 be upheld or reversed.

3 “(B) STANDARD FOR DETERMINATION.—

4 The independent medical review panel’s deter-  
5 mination relating to the medical necessity and  
6 appropriateness, or the experimental or inves-  
7 tigational nature, or the evaluation of the med-  
8 ical facts, of the item, service, or condition in-  
9 volved shall be based on the medical condition  
10 of the participant or beneficiary (including the  
11 medical records of the participant or bene-  
12 ficiary) and valid, relevant scientific evidence  
13 and clinical evidence, including peer-reviewed  
14 medical literature or findings and including ex-  
15 pert opinion.

16 “(C) NO COVERAGE FOR EXCLUDED BENE-  
17 FITS.—Nothing in this subsection shall be con-  
18 strued to permit an independent medical review  
19 panel to require that a group health plan, or  
20 health insurance issuer offering health insur-  
21 ance coverage in connection with the group  
22 health plan, provide coverage for items or serv-  
23 ices for which benefits are specifically excluded  
24 or expressly limited under the plan or coverage  
25 in the plain language of the plan document

(and which are disclosed under section 121(b)(1)(C) of the Bipartisan Patient Protection Act). Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage documents) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage in connection with the group health plan and that is disclosed under section 121(b)(1) of the Bipartisan Patient Protection Act) shall be considered to govern the scope of the benefits that may be required: *Provided*, That the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

“(D) EVIDENCE AND INFORMATION TO BE USED IN MEDICAL REVIEWS.—In making a determination under this subsection, the independent medical review panel shall also consider appropriate and available evidence and information, including the following:

1 “(i) The determination made by the  
2 plan or issuer with respect to the claim  
3 upon internal review and the evidence,  
4 guidelines, or rationale used by the plan or  
5 issuer in reaching such determination.

6 “(ii) The recommendation of the  
7 treating health care professional and the  
8 evidence, guidelines, and rationale used by  
9 the treating health care professional in  
10 reaching such recommendation.

11 “(iii) Additional relevant evidence or  
12 information obtained by the review panel  
13 or submitted by the plan, issuer, partici-  
14 pant, or beneficiary (or an authorized rep-  
15 resentative), or treating health care profes-  
16 sional.

17 “(iv) The plan or coverage document.

18 “(E) INDEPENDENT DETERMINATION.—In  
19 making determinations under this section, a  
20 qualified external review entity and an inde-  
21 pendent medical review panel shall—

22 “(i) consider the claim under review  
23 without deference to the determinations  
24 made by the plan or issuer or the rec-



ommendation of the treating health care professional (if any); and

“(ii) consider, but not be bound by, the definition used by the plan or issuer of ‘medically necessary and appropriate’, or ‘experimental or investigational’, or other substantially equivalent terms that are used by the plan or issuer to describe medical necessity and appropriateness or experimental or investigational nature of the treatment.

“(F) DETERMINATION OF INDEPENDENT MEDICAL REVIEW PANEL.—An independent medical review panel shall, in accordance with the deadlines described in subsection (e), prepare a written determination to uphold or reverse the denial under review. Such written determination shall include—

“(i) the determination of the review panel;

“(ii) the specific reasons of the review panel for such determination, including a summary of the clinical or scientific evidence used in making the determination; and

1                   “(iii) with respect to a determination  
2                   to reverse the denial under review, a time-  
3                   frame within which the plan or issuer must  
4                   comply with such determination.

5                   “(G) NONBINDING NATURE OF ADDI-  
6                   TIONAL RECOMMENDATIONS.—In addition to  
7                   the determination under subparagraph (F), the  
8                   review panel may provide the plan or issuer and  
9                   the treating health care professional with addi-  
10                  tional recommendations in connection with such  
11                  a determination, but any such recommendations  
12                  shall not affect (or be treated as part of) the  
13                  determination and shall not be binding on the  
14                  plan or issuer.

15                  “(e) TIMELINES AND NOTIFICATIONS.—

16                  “(1) TIMELINES FOR INDEPENDENT MEDICAL  
17                  REVIEW.—

18                  “(A) PRIOR AUTHORIZATION DETERMINA-  
19                  TION.—

20                  “(i) IN GENERAL.—The independent  
21                  medical review panel shall make a deter-  
22                  mination on a denial of a claim for benefits  
23                  that is referred to the review panel under  
24                  subsection (c)(3) in accordance with the  
25                  medical exigencies of the case and as soon

1 as possible, but in no case later than 14  
2 days after the date of receipt of informa-  
3 tion under subsection (c)(2) if the review  
4 involves a prior authorization of items or  
5 services and in no case later than 21 days  
6 after the date the request for external re-  
7 view is received.

8 “(ii) EXPEDITED DETERMINATION.—  
9 Notwithstanding clause (i) and subject to  
10 clause (iii), the independent medical review  
11 panel shall make an expedited determina-  
12 tion on a denial of a claim for benefits de-  
13 scribed in clause (i), when a request for  
14 such an expedited determination is made  
15 by a participant or beneficiary (or author-  
16 ized representative) at any time during the  
17 process for making a determination, and a  
18 health care professional certifies, with the  
19 request, that a determination under the  
20 timeline described in clause (i) would seri-  
21 ously jeopardize the life or health of the  
22 participant or beneficiary or the ability of  
23 the participant or beneficiary to maintain  
24 or regain maximum function. Such deter-  
25 mination shall be made in accordance with

1 the medical exigencies of the case and as  
2 soon as possible, but in no case later than  
3 72 hours after the time the request for ex-  
4 ternal review is received by the qualified  
5 external review entity.

6 “(iii) ONGOING CARE DETERMINA-  
7 TION.—Notwithstanding clause (i), in the  
8 case of a review described in such clause  
9 that involves a termination or reduction of  
10 care, the notice of the determination shall  
11 be completed not later than 24 hours after  
12 the time the request for external review is  
13 received by the qualified external review  
14 entity and before the end of the approved  
15 period of care.

16 “(B) RETROSPECTIVE DETERMINATION.—  
17 The independent medical review panel shall  
18 complete a review in the case of a retrospective  
19 determination on an appeal of a denial of a  
20 claim for benefits that is referred to the review  
21 panel under subsection (c)(3) in no case later  
22 than 30 days after the date of receipt of infor-  
23 mation under subsection (c)(2) and in no case  
24 later than 60 days after the date the request

1           for external review is received by the qualified  
2           external review entity.

3           “(2) NOTIFICATION OF DETERMINATION.—The  
4           external review entity shall ensure that the plan or  
5           issuer, the participant, or beneficiary (or authorized  
6           representative) and the treating health care profes-  
7           sional (if any) receives a copy of the written deter-  
8           mination of the independent medical review panel  
9           prepared under subsection (d)(3)(F). Nothing in this  
10          paragraph shall be construed as preventing an entity  
11          or review panel from providing an initial oral notice  
12          of the review panel’s determination.

13          “(3) FORM OF NOTICES.—Determinations and  
14          notices under this subsection shall be written in a  
15          manner calculated to be understood by a participant.

16          “(f) COMPLIANCE.—

17                 “(1) APPLICATION OF DETERMINATIONS.—

18                         “(A) EXTERNAL REVIEW DETERMINATIONS  
19                         BINDING ON PLAN.—The determinations of an  
20                         external review entity and an independent med-  
21                         ical review panel under this section shall be  
22                         binding upon the plan or issuer involved.

23                         “(B) COMPLIANCE WITH DETERMINA-  
24                         TION.—If the determination of an independent  
25                         medical review panel is to reverse the denial,

1 the plan or issuer, upon the receipt of such de-  
2 termination, shall authorize coverage to comply  
3 with the medical review panel's determination  
4 in accordance with the timeframe established by  
5 the medical review panel.

6 “(2) FAILURE TO COMPLY.—

7 “(A) IN GENERAL.—If a plan or issuer  
8 fails to comply with the timeframe established  
9 under paragraph (1)(B) with respect to a par-  
10 ticipant or beneficiary, where such failure to  
11 comply is caused by the plan or issuer, the par-  
12 ticipant, or beneficiary may obtain the items or  
13 services involved (in a manner consistent with  
14 the determination of the independent medical  
15 review panel) from any provider regardless of  
16 whether such provider is a participating pro-  
17 vider under the plan or coverage.

18 “(B) REIMBURSEMENT.—

19 “(i) IN GENERAL.—Where a partici-  
20 pant or beneficiary obtains items or serv-  
21 ices in accordance with subparagraph (A),  
22 the plan or issuer involved shall provide for  
23 reimbursement of the costs of such items  
24 or services. Such reimbursement shall be  
25 made to the treating health care profes-

1 sional or to the participant or beneficiary  
2 (in the case of a participant or beneficiary  
3 who pays for the costs of such items or  
4 services).

5 “(ii) AMOUNT.—The plan or issuer  
6 shall fully reimburse a professional, partici-  
7 pant or beneficiary under clause (i) for the  
8 total costs of the items or services provided  
9 (regardless of any plan limitations that  
10 may apply to the coverage of such items or  
11 services) so long as the items or services  
12 were provided in a manner consistent with  
13 the determination of the independent med-  
14 ical review panel.

15 “(C) FAILURE TO REIMBURSE.—Where a  
16 plan or issuer fails to provide reimbursement to  
17 a professional, participant, or beneficiary in ac-  
18 cordance with this paragraph, the professional,  
19 participant, or beneficiary may commence a  
20 civil action (or utilize other remedies available  
21 under law) to recover only the amount of any  
22 such reimbursement that is owed by the plan or  
23 issuer and any necessary legal costs or expenses  
24 (including attorney’s fees) incurred in recov-  
25 ering such reimbursement.

1           “(D) AVAILABLE REMEDIES.—The rem-  
2 edies provided under this paragraph are in ad-  
3 dition to any other available remedies.

4           “(3) PENALTIES AGAINST AUTHORIZED OFFI-  
5 CIALS FOR REFUSING TO AUTHORIZE THE DETER-  
6 MINATION OF AN EXTERNAL REVIEW ENTITY.—

7           “(A) MONETARY PENALTIES.—

8           “(i) IN GENERAL.—In any case in  
9 which the determination of an external re-  
10 view entity is not followed by a group  
11 health plan, or by a health insurance issuer  
12 offering health insurance coverage in con-  
13 nection with the group health plan, any  
14 person who, acting in the capacity of au-  
15 thorizing the benefit, causes such refusal  
16 may, in the discretion of a court of com-  
17 petent jurisdiction, be liable to an ag-  
18 grieved participant or beneficiary for a civil  
19 penalty in an amount of up to \$1,000 a  
20 day from the date on which the determina-  
21 tion was transmitted to the plan or issuer  
22 by the external review entity until the date  
23 the refusal to provide the benefit is cor-  
24 rected.



1                   “(ii) ADDITIONAL PENALTY FOR FAIL-  
2                   ING TO FOLLOW TIMELINE.—In any case  
3                   in which treatment was not commenced by  
4                   the plan in accordance with the determina-  
5                   tion of an independent medical review  
6                   panel, the Secretary shall assess a civil  
7                   penalty of \$10,000 against the plan and  
8                   the plan shall pay such penalty to the par-  
9                   ticipant or beneficiary involved.

10                  “(B) CEASE AND DESIST ORDER AND  
11                  ORDER OF ATTORNEY’S FEES.—In any action  
12                  described in subparagraph (A) brought by a  
13                  participant or beneficiary with respect to a  
14                  group health plan, or a health insurance issuer  
15                  offering health insurance coverage in connection  
16                  with the group health plan, in which a plaintiff  
17                  alleges that a person referred to in such sub-  
18                  paragraph has taken an action resulting in a  
19                  refusal of a benefit determined by an external  
20                  review entity to be covered, or has failed to take  
21                  an action for which such person is responsible  
22                  under the terms and conditions of the plan or  
23                  coverage and which is necessary under the plan  
24                  or coverage for authorizing a benefit, the court

1 shall cause to be served on the defendant an  
2 order requiring the defendant—

3 “(i) to cease and desist from the al-  
4 leged action or failure to act; and

5 “(ii) to pay to the plaintiff a reason-  
6 able attorney’s fee and other reasonable  
7 costs relating to the prosecution of the ac-  
8 tion on the charges on which the plaintiff  
9 prevails.

10 “(C) ADDITIONAL CIVIL PENALTIES.—

11 “(i) IN GENERAL.—In addition to any  
12 penalty imposed under subparagraph (A)  
13 or (B), the appropriate Secretary may as-  
14 sess a civil penalty against a person acting  
15 in the capacity of authorizing a benefit de-  
16 termined by an external review entity for  
17 one or more group health plans, or health  
18 insurance issuers offering health insurance  
19 coverage in connection with the group  
20 health plan, for—

21 “(I) any pattern or practice of  
22 repeated refusal to authorize a benefit  
23 determined by an external review enti-  
24 ty to be covered; or

1                   “(II) any pattern or practice of  
2                   repeated violations of the require-  
3                   ments of this section with respect to  
4                   such plan or coverage.

5                   “(ii) STANDARD OF PROOF AND  
6                   AMOUNT OF PENALTY.—Such penalty shall  
7                   be payable only upon proof by clear and  
8                   convincing evidence of such pattern or  
9                   practice and shall be in an amount not to  
10                  exceed the lesser of—

11                  “(I) 25 percent of the aggregate  
12                  value of benefits shown by the appro-  
13                  priate Secretary to have not been pro-  
14                  vided, or unlawfully delayed, in viola-  
15                  tion of this section under such pattern  
16                  or practice; or

17                  “(II) \$500,000.

18                  “(D) REMOVAL AND DISQUALIFICATION.—  
19                  Any person acting in the capacity of author-  
20                  izing benefits who has engaged in any such pat-  
21                  tern or practice described in subparagraph  
22                  (C)(i) with respect to a plan or coverage, upon  
23                  the petition of the appropriate Secretary, may  
24                  be removed by the court from such position,  
25                  and from any other involvement, with respect to

1           such a plan or coverage, and may be precluded  
2           from returning to any such position or involve-  
3           ment for a period determined by the court.

4           “(4) PROTECTION OF LEGAL RIGHTS.—Nothing  
5           in this section or section 503A or 503B shall be con-  
6           strued as altering or eliminating any cause of action  
7           or legal rights or remedies of participants or bene-  
8           ficiaries, and others under State or Federal law (in-  
9           cluding sections 502 and 503 of the Employee Re-  
10          tirement Income Security Act of 1974), including  
11          the right to file judicial actions to enforce rights.

12          “(g) QUALIFICATIONS OF INDEPENDENT MEDICAL  
13 REVIEWERS.—

14           “(1) IN GENERAL.—In referring a denial to an  
15          independent medical review panel to conduct inde-  
16          pendent medical review under subsection (c), the  
17          qualified external review entity shall ensure that—

18                   “(A) each independent medical reviewer  
19                  meets the qualifications described in paragraphs  
20                  (2) and (3);

21                   “(B) with respect to each review, the re-  
22                  view panel meets the requirements of paragraph  
23                  (4) and at least 1 reviewer on the panel meets  
24                  the requirements described in paragraph (5);  
25                  and

1           “(C) compensation provided by the entity  
2           to each reviewer is consistent with paragraph  
3           (6).

4           “(2) LICENSURE AND EXPERTISE.—Each inde-  
5           pendent medical reviewer shall be a physician  
6           (allopathic or osteopathic) or health care profes-  
7           sional who—

8           “(A) is appropriately credentialed or li-  
9           censed in 1 or more States to deliver health  
10          care services; and

11          “(B) typically treats the condition, makes  
12          the diagnosis, or provides the type of treatment  
13          under review.

14          “(3) INDEPENDENCE.—

15          “(A) IN GENERAL.—Subject to subpara-  
16          graph (B), each independent medical reviewer  
17          in a case shall—

18                 “(i) not be a related party (as defined  
19                 in paragraph (7));

20                 “(ii) not have a material familial, fi-  
21                 nancial, or professional relationship with  
22                 such a party; and

23                 “(iii) not otherwise have a conflict of  
24                 interest with such a party (as determined  
25                 under regulations).

1           “(B) EXCEPTION.—Nothing in subpara-  
2 graph (A) shall be construed to—

3           “(i) prohibit an individual, solely on  
4 the basis of affiliation with the plan or  
5 issuer, from serving as an independent  
6 medical reviewer if—

7           “(I) a non-affiliated individual is  
8 not reasonably available;

9           “(II) the affiliated individual is  
10 not involved in the provision of items  
11 or services in the case under review;

12           “(III) the fact of such an affili-  
13 ation is disclosed to the plan or issuer  
14 and the participant or beneficiary (or  
15 authorized representative) and neither  
16 party objects; and

17           “(IV) the affiliated individual is  
18 not an employee of the plan or issuer  
19 and does not provide services exclu-  
20 sively or primarily to or on behalf of  
21 the plan or issuer;

22           “(ii) prohibit an individual who has  
23 staff privileges at the institution where the  
24 treatment involved takes place from serv-  
25 ing as an independent medical reviewer

1           merely on the basis of such affiliation if  
2           the affiliation is disclosed to the plan or  
3           issuer and the participant or beneficiary  
4           (or authorized representative), and neither  
5           party objects; or

6           “(iii) prohibit receipt of compensation  
7           by an independent medical reviewer from  
8           an entity if the compensation is provided  
9           consistent with paragraph (6).

10          “(4) PRACTICING HEALTH CARE PROFESSIONAL  
11          IN SAME FIELD.—

12               “(A) IN GENERAL.—In a case involving  
13           treatment, or the provision of items or  
14           services—

15               “(i) by a physician, each reviewer  
16           shall be a practicing physician (allopathic  
17           or osteopathic) of the same or similar spe-  
18           cialty, as a physician who, acting within  
19           the appropriate scope of practice within  
20           the State in which the service is provided  
21           or rendered, typically treats the condition,  
22           makes the diagnosis, or provides the type  
23           of treatment under review; or

24               “(ii) by a non-physician health care  
25           professional, the independent medical re-

view panel shall include at least one practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

“(B) PRACTICING DEFINED.—For purposes of this paragraph, the term ‘practicing’ means, with respect to an individual who is a physician or other health care professional that the individual provides health care services to individual patients on average at least 2 days per week.

“(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

“(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified external review entity to an independent medical reviewer in connection with a review under this section shall—

“(A) not exceed a reasonable level; and



1 “(B) not be contingent on the decision ren-  
2 dered by the reviewer.

3 “(7) RELATED PARTY DEFINED.—For purposes  
4 of this section, the term ‘related party’ means, with  
5 respect to a denial of a claim under a plan or cov-  
6 erage relating to a participant or beneficiary, any of  
7 the following:

8 “(A) The plan, plan sponsor, or issuer in-  
9 volved, or any fiduciary, officer, director, or em-  
10 ployee of such plan, plan sponsor, or issuer.

11 “(B) The participant or beneficiary (or au-  
12 thorized representative).

13 “(C) The health care professional that pro-  
14 vides the items or services involved in the de-  
15 nial.

16 “(D) The institution at which the items or  
17 services (or treatment) involved in the denial  
18 are provided.

19 “(E) The manufacturer of any drug or  
20 other item that is included in the items or serv-  
21 ices involved in the denial.

22 “(F) Any other party determined under  
23 any regulations to have a substantial interest in  
24 the denial involved.

25 “(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

1           “(1) SELECTION OF QUALIFIED EXTERNAL RE-  
2       VIEW ENTITIES.—

3           “(A) LIMITATION ON PLAN OR ISSUER SE-  
4       LECTION.—The appropriate Secretary shall im-  
5       plement procedures—

6           “(i) to assure that the selection proc-  
7       ess among qualified external review entities  
8       will not create any incentives for external  
9       review entities to make a decision in a bi-  
10      ased manner; and

11          “(ii) for auditing a sample of deci-  
12      sions by such entities to assure that no  
13      such decisions are made in a biased man-  
14      ner.

15      No such selection process under the procedures  
16      implemented by the appropriate Secretary may  
17      give either the patient or the plan or issuer any  
18      ability to determine or influence the selection of  
19      a qualified external review entity to review the  
20      case of any participant or beneficiary.

21          “(B) STATE AUTHORITY WITH RESPECT  
22      TO QUALIFIED EXTERNAL REVIEW ENTITIES  
23      FOR HEALTH INSURANCE ISSUERS.—With re-  
24      spect to health insurance issuers offering health  
25      insurance coverage in connection with the group

1 health plan in a State, the State may provide  
2 for external review activities to be conducted by  
3 a qualified external review entity that is des-  
4 ignated by the State or that is selected by the  
5 State in a manner determined by the State to  
6 assure an unbiased determination.

7 “(2) CONTRACT WITH QUALIFIED EXTERNAL  
8 REVIEW ENTITY.—Except as provided in paragraph  
9 (1)(B), the external review process of a plan or  
10 issuer under this section shall be conducted under a  
11 contract between the plan or issuer and 1 or more  
12 qualified external review entities (as defined in para-  
13 graph (4)(A)).

14 “(3) TERMS AND CONDITIONS OF CONTRACT.—  
15 The terms and conditions of a contract under para-  
16 graph (2) shall—

17 “(A) be consistent with the standards the  
18 appropriate Secretary shall establish to assure  
19 there is no real or apparent conflict of interest  
20 in the conduct of external review activities; and

21 “(B) provide that the costs of the external  
22 review process shall be borne by the plan or  
23 issuer.

24 Subparagraph (B) shall not be construed as apply-  
25 ing to the imposition of a filing fee under subsection

1 (b)(2)(A)(iv) or costs incurred by the participant or  
2 beneficiary (or authorized representative) or treating  
3 health care professional (if any) in support of the re-  
4 view, including the provision of additional evidence  
5 or information.

6 “(4) QUALIFICATIONS.—

7 “(A) IN GENERAL.—In this section, the  
8 term ‘qualified external review entity’ means, in  
9 relation to a plan or issuer, an entity that is  
10 initially certified (and periodically recertified)  
11 under subparagraph (C) as meeting the fol-  
12 lowing requirements:

13 “(i) The entity has (directly or  
14 through contracts or other arrangements)  
15 sufficient medical, legal, and other exper-  
16 tise and sufficient staffing to carry out du-  
17 ties of a qualified external review entity  
18 under this section on a timely basis, in-  
19 cluding making determinations under sub-  
20 section (b)(2)(A) and providing for inde-  
21 pendent medical reviews under subsection  
22 (d).

23 “(ii) The entity is not a plan or issuer  
24 or an affiliate or a subsidiary of a plan or  
25 issuer, and is not an affiliate or subsidiary

1 of a professional or trade association of  
2 plans or issuers or of health care providers.

3 “(iii) The entity has provided assur-  
4 ances that it will conduct external review  
5 activities consistent with the applicable re-  
6 quirements of this section and standards  
7 specified in subparagraph (C), including  
8 that it will not conduct any external review  
9 activities in a case unless the independence  
10 requirements of subparagraph (B) are met  
11 with respect to the case.

12 “(iv) The entity has provided assur-  
13 ances that it will provide information in a  
14 timely manner under subparagraph (D).

15 “(v) The entity meets such other re-  
16 quirements as the appropriate Secretary  
17 provides by regulation.

18 “(B) INDEPENDENCE REQUIREMENTS.—

19 “(i) IN GENERAL.—Subject to clause  
20 (ii), an entity meets the independence re-  
21 quirements of this subparagraph with re-  
22 spect to any case if the entity—

23 “(I) is not a related party (as de-  
24 fined in subsection (g)(7));

1 “(II) does not have a material fa-  
2 milial, financial, or professional rela-  
3 tionship with such a party; and

4 “(III) does not otherwise have a  
5 conflict of interest with such a party  
6 (as determined under regulations).

7 “(ii) EXCEPTION FOR REASONABLE  
8 COMPENSATION.—Nothing in clause (i)  
9 shall be construed to prohibit receipt by a  
10 qualified external review entity of com-  
11 pensation from a plan or issuer for the  
12 conduct of external review activities under  
13 this section if the compensation is provided  
14 consistent with clause (iii).

15 “(iii) LIMITATIONS ON ENTITY COM-  
16 PENSATION.—Compensation provided by a  
17 plan or issuer to a qualified external review  
18 entity in connection with reviews under  
19 this section shall—

20 “(I) not exceed a reasonable  
21 level; and

22 “(II) not be contingent on any  
23 decision rendered by the entity or by  
24 any independent medical review panel.

1                   “(C) CERTIFICATION AND RECERTIFI-  
2                   CATION PROCESS.—

3                   “(i) IN GENERAL.—The initial certifi-  
4                   cation and recertification of a qualified ex-  
5                   ternal review entity shall be made—

6                   “(I) under a process that is rec-  
7                   ognized or approved by the appro-  
8                   priate Secretary; or

9                   “(II) by a qualified private  
10                  standard-setting organization that is  
11                  approved by the appropriate Secretary  
12                  under clause (iii).

13                 In taking action under subclause (I), the  
14                 appropriate Secretary shall give deference  
15                 to entities that are under contract with the  
16                 Federal Government or with an applicable  
17                 State authority to perform functions of the  
18                 type performed by qualified external review  
19                 entities.

20                 “(ii) PROCESS.—The appropriate Sec-  
21                 retary shall not recognize or approve a  
22                 process under clause (i)(I) unless the proc-  
23                 ess applies standards (as promulgated in  
24                 regulations) that ensure that a qualified  
25                 external review entity—

1                   “(I) will carry out (and has car-  
2                   ried out, in the case of recertification)  
3                   the responsibilities of such an entity  
4                   in accordance with this section, in-  
5                   cluding meeting applicable deadlines;

6                   “(II) will meet (and has met, in  
7                   the case of recertification) appropriate  
8                   indicators of fiscal integrity;

9                   “(III) will maintain (and has  
10                  maintained, in the case of recertifi-  
11                  cation) appropriate confidentiality  
12                  with respect to individually identifi-  
13                  able health information obtained in  
14                  the course of conducting external re-  
15                  view activities; and

16                  “(IV) in the case of recertifi-  
17                  cation, shall review the matters de-  
18                  scribed in clause (iv).

19                  “(iii) APPROVAL OF QUALIFIED PRI-  
20                  VATE STANDARD-SETTING ORGANIZA-  
21                  TIONS.—For purposes of clause (i)(II), the  
22                  appropriate Secretary may approve a quali-  
23                  fied private standard-setting organization  
24                  if such Secretary finds that the organiza-  
25                  tion only certifies (or recertifies) external



1 review entities that meet at least the  
2 standards required for the certification (or  
3 recertification) of external review entities  
4 under clause (ii).

5 “(iv) CONSIDERATIONS IN RECERTIFI-  
6 CATIONS.—In conducting recertifications of  
7 a qualified external review entity under  
8 this paragraph, the appropriate Secretary  
9 or organization conducting the recertifi-  
10 cation shall review compliance of the entity  
11 with the requirements for conducting ex-  
12 ternal review activities under this section,  
13 including the following:

14 “(I) Provision of information  
15 under subparagraph (D).

16 “(II) Adherence to applicable  
17 deadlines (both by the entity and by  
18 independent medical review panels it  
19 refers cases to).

20 “(III) Compliance with limita-  
21 tions on compensation (with respect to  
22 both the entity and independent med-  
23 ical review panels it refers cases to).

24 “(IV) Compliance with applicable  
25 independence requirements.

1                   “(V) Compliance with the re-  
2                   quirement of subsection (d)(1) that  
3                   only medically reviewable decisions  
4                   shall be the subject of independent  
5                   medical review and with the require-  
6                   ment of subsection (d)(3) that inde-  
7                   pendent medical review panels may  
8                   not require coverage for specifically  
9                   excluded benefits.

10                  “(v) PERIOD OF CERTIFICATION OR  
11                  RECERTIFICATION.—A certification or re-  
12                  certification provided under this paragraph  
13                  shall extend for a period not to exceed 2  
14                  years.

15                  “(vi) REVOCATION.—A certification or  
16                  recertification under this paragraph may  
17                  be revoked by the appropriate Secretary or  
18                  by the organization providing such certifi-  
19                  cation upon a showing of cause. The Sec-  
20                  retary, or organization, shall revoke a cer-  
21                  tification or deny a recertification with re-  
22                  spect to an entity if there is a showing that  
23                  the entity has a pattern or practice of or-  
24                  dering coverage for benefits that are spe-

1 cifically excluded under the plan or cov-  
2 erage.

3 “(vii) PETITION FOR DENIAL OR  
4 WITHDRAWAL.—An individual may petition  
5 the Secretary, or an organization providing  
6 the certification involves, for a denial of re-  
7 certification or a withdrawal of a certifi-  
8 cation with respect to an entity under this  
9 subparagraph if there is a pattern or prac-  
10 tice of such entity failing to meet a re-  
11 quirement of this section.

12 “(viii) SUFFICIENT NUMBER OF ENTI-  
13 TIES.—The appropriate Secretary shall  
14 certify and recertify a number of external  
15 review entities which is sufficient to ensure  
16 the timely and efficient provision of review  
17 services.

18 “(D) PROVISION OF INFORMATION.—

19 “(i) IN GENERAL.—A qualified exter-  
20 nal review entity shall provide to the ap-  
21 propriate Secretary, in such manner and at  
22 such times as such Secretary may require,  
23 such information (relating to the denials  
24 which have been referred to the entity for  
25 the conduct of external review under this

1 section) as such Secretary determines ap-  
2 propriate to assure compliance with the  
3 independence and other requirements of  
4 this section to monitor and assess the qual-  
5 ity of its external review activities and lack  
6 of bias in making determinations. Such in-  
7 formation shall include information de-  
8 scribed in clause (ii) but shall not include  
9 individually identifiable medical informa-  
10 tion.

11 “(ii) INFORMATION TO BE IN-  
12 CLUDED.—The information described in  
13 this subclause with respect to an entity is  
14 as follows:

15 “(I) The number and types of de-  
16 nials for which a request for review  
17 has been received by the entity.

18 “(II) The disposition by the enti-  
19 ty of such denials, including the num-  
20 ber referred to a independent medical  
21 review panel and the reasons for such  
22 dispositions (including the application  
23 of exclusions), on a plan or issuer-spe-  
24 cific basis and on a health care spe-  
25 cialty-specific basis.

1 “(III) The length of time in mak-  
2 ing determinations with respect to  
3 such denials.

4 “(IV) Updated information on  
5 the information required to be sub-  
6 mitted as a condition of certification  
7 with respect to the entity’s perform-  
8 ance of external review activities.

9 “(iii) INFORMATION TO BE PROVIDED  
10 TO CERTIFYING ORGANIZATION.—

11 “(I) IN GENERAL.—In the case  
12 of a qualified external review entity  
13 which is certified (or recertified)  
14 under this subsection by a  
15 qualifiedprivate standard-setting orga-  
16 nization, at the request of the organi-  
17 zation, the entity shall provide the or-  
18 ganization with the information pro-  
19 vided to the appropriate Secretary  
20 under clause (i).

21 “(II) ADDITIONAL INFORMA-  
22 TION.—Nothing in this subparagraph  
23 shall be construed as preventing such  
24 an organization from requiring addi-  
25 tional information as a condition of

1                   certification or recertification of an  
2                   entity.

3                   “(iv) USE OF INFORMATION.—Infor-  
4                   mation provided under this subparagraph  
5                   may be used by the appropriate Secretary  
6                   and qualified private standard-setting or-  
7                   ganizations to conduct oversight of quali-  
8                   fied external review entities, including re-  
9                   certification of such entities, and shall be  
10                  made available to the public in an appro-  
11                  priate manner.

12                  “(E) LIMITATION ON LIABILITY.—No  
13                  qualified external review entity having a con-  
14                  tract with a plan or issuer, and no person who  
15                  is employed by any such entity or who furnishes  
16                  professional services to such entity (including as  
17                  an independent medical review panel), shall be  
18                  held by reason of the performance of any duty,  
19                  function, or activity required or authorized pur-  
20                  suant to this section, to be civilly liable under  
21                  any law of the United States or of any State  
22                  (or political subdivision thereof) if there was no  
23                  actual malice or gross misconduct in the per-  
24                  formance of such duty, function, or activity.

1           “(5) REPORT.—Not later than 12 months after  
2           the general effective date referred to in section 601  
3           of the Bipartisan Patient Protection Act, the Gen-  
4           eral Accounting Office shall prepare and submit to  
5           the appropriate committees of Congress a report  
6           concerning—

7                   “(A) the information that is provided  
8                   under paragraph (3)(D);

9                   “(B) the number of denials that have been  
10                  upheld by independent medical review panels  
11                  and the number of denials that have been re-  
12                  versed by such panels; and

13                  “(C) the extent to which independent med-  
14                  ical review panels are requiring coverage for  
15                  benefits that are specifically excluded under the  
16                  plans or coverage.”.

17 **SEC. 105. HEALTH CARE CONSUMER ASSISTANCE FUND.**

18           (a) GRANTS.—

19                   (1) IN GENERAL.—The Secretary of Health and  
20                  Human Services (referred to in this section as the  
21                  “Secretary”) shall establish a fund, to be known as  
22                  the “Health Care Consumer Assistance Fund”, to be  
23                  used to award grants to eligible States to carry out  
24                  consumer assistance activities (including programs  
25                  established by States prior to the enactment of this

1 Act) designed to provide information, assistance, and  
2 referrals to consumers of health insurance products.

3 (2) STATE ELIGIBILITY.—To be eligible to re-  
4 ceive a grant under this subsection a State shall pre-  
5 pare and submit to the Secretary an application at  
6 such time, in such manner, and containing such in-  
7 formation as the Secretary may require, including a  
8 State plan that describes—

9 (A) the manner in which the State will en-  
10 sure that the health care consumer assistance  
11 office (established under paragraph (4)) will  
12 educate and assist health care consumers in ac-  
13 cessing needed care;

14 (B) the manner in which the State will co-  
15 ordinate and distinguish the services provided  
16 by the health care consumer assistance office  
17 with the services provided by Federal, State and  
18 local health-related ombudsman, information,  
19 protection and advocacy, insurance, and fraud  
20 and abuse programs;

21 (C) the manner in which the State will  
22 provide information, outreach, and services to  
23 underserved, minority populations with limited  
24 English proficiency and populations residing in  
25 rural areas;



1 (D) the manner in which the State will  
2 oversee the health care consumer assistance of-  
3 fice, its activities, product materials and evalu-  
4 ate program effectiveness;

5 (E) the manner in which the State will en-  
6 sure that funds made available under this sec-  
7 tion will be used to supplement, and not sup-  
8 plant, any other Federal, State, or local funds  
9 expended to provide services for programs de-  
10 scribed under this section and those described  
11 in subparagraphs (C) and (D);

12 (F) the manner in which the State will en-  
13 sure that health care consumer office personnel  
14 have the professional background and training  
15 to carry out the activities of the office; and

16 (G) the manner in which the State will en-  
17 sure that consumers have direct access to con-  
18 sumer assistance personnel during regular busi-  
19 ness hours.

20 (3) AMOUNT OF GRANT.—

21 (A) IN GENERAL.—From amounts appro-  
22 priated under subsection (b) for a fiscal year,  
23 the Secretary shall award a grant to a State in  
24 an amount that bears the same ratio to such  
25 amounts as the number of individuals within

1 the State covered under a group health plan or  
2 under health insurance coverage in connection  
3 with the group health plan offered by a health  
4 insurance issuer bears to the total number of  
5 individuals so covered in all States (as deter-  
6 mined by the Secretary). Any amounts provided  
7 to a State under this subsection that are not  
8 used by the State shall be remitted to the Sec-  
9 retary and reallocated in accordance with this  
10 subparagraph.

11 (B) MINIMUM AMOUNT.—In no case shall  
12 the amount provided to a State under a grant  
13 under this subsection for a fiscal year be less  
14 than an amount equal to 0.5 percent of the  
15 amount appropriated for such fiscal year to  
16 carry out this section.

17 (C) NON-FEDERAL CONTRIBUTIONS.—A  
18 State will provide for the collection of non-Fed-  
19 eral contributions for the operation of the office  
20 in an amount that is not less than 25 percent  
21 of the amount of Federal funds provided to the  
22 State under this section.

23 (4) PROVISION OF FUNDS FOR ESTABLISHMENT  
24 OF OFFICE.—

1           (A) IN GENERAL.—From amounts pro-  
2           vided under a grant under this subsection, a  
3           State shall, directly or through a contract with  
4           an independent, nonprofit entity with dem-  
5           onstrated experience in serving the needs of  
6           health care consumers, provide for the estab-  
7           lishment and operation of a State health care  
8           consumer assistance office.

9           (B) ELIGIBILITY OF ENTITY.—To be eligi-  
10          ble to enter into a contract under subparagraph  
11          (A), an entity shall demonstrate that it has the  
12          technical, organizational, and professional ca-  
13          pacity to deliver the services described in sub-  
14          section (b) to all public and private health in-  
15          surance participants or beneficiaries.

16          (C) EXISTING STATE ENTITY.—Nothing in  
17          this section shall prevent the funding of an ex-  
18          isting health care consumer assistance program  
19          that otherwise meets the requirements of this  
20          section.

21       (b) USE OF FUNDS.—

22           (1) BY STATE.—A State shall use amounts pro-  
23           vided under a grant awarded under this section to  
24           carry out consumer assistance activities directly or  
25           by contract with an independent, non-profit organi-

1        zation. An eligible entity may use some reasonable  
2        amount of such grant to ensure the adequate train-  
3        ing of personnel carrying out such activities. To re-  
4        ceive amounts under this subsection, an eligible enti-  
5        ty shall provide consumer assistance services,  
6        including—

7                (A) the operation of a toll-free telephone  
8                hotline to respond to consumer requests;

9                (B) the dissemination of appropriate edu-  
10                cational materials on available health insurance  
11                products and on how best to access health care  
12                and the rights and responsibilities of health  
13                care consumers;

14                (C) the provision of education on effective  
15                methods to promptly and efficiently resolve  
16                questions, problems, and grievances;

17                (D) the coordination of educational and  
18                outreach efforts with health plans, health care  
19                providers, payers, and governmental agencies;

20                (E) referrals to appropriate private and  
21                public entities to resolve questions, problems  
22                and grievances; and

23                (F) the provision of information and as-  
24                sistance, including acting as an authorized rep-  
25                resentative, regarding internal, external, or ad-

1           ministrative grievances or appeals procedures in  
2           nonlitigative settings to appeal the denial, ter-  
3           mination, or reduction of health care services,  
4           or the refusal to pay for such services, under a  
5           group health plan or health insurance coverage  
6           in connection with the group health plan offered  
7           by a health insurance issuer.

8           (2) CONFIDENTIALITY AND ACCESS TO INFOR-  
9           MATION.—

10           (A) STATE ENTITY.—With respect to a  
11           State that directly establishes a health care con-  
12           sumer assistance office, such office shall estab-  
13           lish and implement procedures and protocols in  
14           accordance with applicable Federal and State  
15           laws.

16           (B) CONTRACT ENTITY.—With respect to a  
17           State that, through contract, establishes a  
18           health care consumer assistance office, such of-  
19           fice shall establish and implement procedures  
20           and protocols, consistent with applicable Fed-  
21           eral and State laws, to ensure the confiden-  
22           tiality of all information shared by a partici-  
23           pant, beneficiary, or their personal representa-  
24           tive and their health care providers, group  
25           health plans, or health insurance insurers with

1 the office and to ensure that no such informa-  
2 tion is used by the office, or released or dis-  
3 closed to State agencies or outside persons or  
4 entities without the prior written authorization  
5 (in accordance with section 164.508 of title 45,  
6 Code of Federal Regulations) of the individual  
7 or personal representative. The office may, con-  
8 sistent with applicable Federal and State con-  
9 fidentiality laws, collect, use or disclose aggre-  
10 gate information that is not individually identi-  
11 fiable (as defined in section 164.501 of title 45,  
12 Code of Federal Regulations). The office shall  
13 provide a written description of the policies and  
14 procedures of the office with respect to the  
15 manner in which health information may be  
16 used or disclosed to carry out consumer assist-  
17 ance activities. The office shall provide health  
18 care providers, group health plans, or health in-  
19 surance issuers with a written authorization (in  
20 accordance with section 164.508 of title 45,  
21 Code of Federal Regulations) to allow the office  
22 to obtain medical information relevant to the  
23 matter before the office.

24 (3) AVAILABILITY OF SERVICES.—The health  
25 care consumer assistance office of a State shall not

1 discriminate in the provision of information, refer-  
2 rals, and services regardless of the source of the in-  
3 dividual's health insurance coverage in connection  
4 with the group health plan or prospective coverage,  
5 including individuals covered under a group health  
6 plan or health insurance coverage in connection with  
7 the group health plan offered by a health insurance  
8 issuer, the medicare or medicaid programs under  
9 title XVIII or XIX of the Social Security Act (42  
10 U.S.C. 1395 and 1396 et seq.), or under any other  
11 Federal or State health care program.

12 (4) DESIGNATION OF RESPONSIBILITIES.—

13 (A) WITHIN EXISTING STATE ENTITY.—If  
14 the health care consumer assistance office of a  
15 State is located within an existing State regu-  
16 latory agency or office of an elected State offi-  
17 cial, the State shall ensure that—

18 (i) there is a separate delineation of  
19 the funding, activities, and responsibilities  
20 of the office as compared to the other  
21 funding, activities, and responsibilities of  
22 the agency; and

23 (ii) the office establishes and imple-  
24 ments procedures and protocols to ensure  
25 the confidentiality of all information

1 shared by a participant, beneficiary, or  
2 their personal representative and their  
3 health care providers, group health plans,  
4 or health insurance issuers with the office  
5 and to ensure that no information is dis-  
6 closed to the State agency or office without  
7 the written authorization of the individual  
8 or their personal representative in accord-  
9 ance with paragraph (2).

10 (B) CONTRACT ENTITY.—In the case of an  
11 entity that enters into a contract with a State  
12 under subsection (a)(3), the entity shall provide  
13 assurances that the entity has no conflict of in-  
14 terest in carrying out the activities of the office  
15 and that the entity is independent of group  
16 health plans, health insurance issuers, pro-  
17 viders, payers, and regulators of health care.

18 (5) SUBCONTRACTS.—The health care con-  
19 sumer assistance office of a State may carry out ac-  
20 tivities and provide services through contracts en-  
21 tered into with 1 or more nonprofit entities so long  
22 as the office can demonstrate that all of the require-  
23 ments of this section are complied with by the office.

24 (6) TERM.—A contract entered into under this  
25 subsection shall be for a term of 3 years.



1 (c) REPORT.—Not later than 1 year after the Sec-  
 2 retary first awards grants under this section, and annually  
 3 thereafter, the Secretary shall prepare and submit to the  
 4 appropriate committees of Congress a report concerning  
 5 the activities funded under this section and the effective-  
 6 ness of such activities in resolving health care-related  
 7 problems and grievances.

8 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
 9 are authorized to be appropriated such sums as may be  
 10 necessary to carry out this section.

## 11 **Subtitle B—Access to Care**

### 12 **SEC. 111. CONSUMER CHOICE OPTION.**

13 (a) IN GENERAL.—If—

14 (1) a health insurance issuer providing health  
 15 insurance coverage in connection with a group health  
 16 plan offers to enrollees health insurance coverage  
 17 which provides for coverage of services (including  
 18 physician pathology services) only if such services  
 19 are furnished through health care professionals and  
 20 providers who are members of a network of health  
 21 care professionals and providers who have entered  
 22 into a contract with the issuer to provide such serv-  
 23 ices, or

24 (2) a group health plan offers to participants or  
 25 beneficiaries health benefits which provide for cov-

1        erage of services only if such services are furnished  
2        through health care professionals and providers who  
3        are members of a network of health care profes-  
4        sionals and providers who have entered into a con-  
5        tract with the plan to provide such services,  
6 then the issuer or plan shall also offer or arrange to be  
7 offered to such enrollees, participants, or beneficiaries (at  
8 the time of enrollment and during an annual open season  
9 as provided under subsection (c)) the option of health in-  
10 surance coverage or health benefits which provide for cov-  
11 erage of such services which are not furnished through  
12 health care professionals and providers who are members  
13 of such a network unless such enrollees, participants, or  
14 beneficiaries are offered such non-network coverage  
15 through another group health plan or through another  
16 health insurance issuer in the group market.

17        (b) ADDITIONAL COSTS.—The amount of any addi-  
18 tional premium charged by the health insurance issuer or  
19 group health plan for the additional cost of the creation  
20 and maintenance of the option described in subsection (a)  
21 and the amount of any additional cost sharing imposed  
22 under such option shall be borne by the enrollee, partici-  
23 pant, or beneficiary unless it is paid by the health plan  
24 sponsor or group health plan through agreement with the  
25 health insurance issuer.

1       (c) OPEN SEASON.—An enrollee, participant, or ben-  
2       eficiary, may change to the offering provided under this  
3       section only during a time period determined by the health  
4       insurance issuer or group health plan. Such time period  
5       shall occur at least annually.

6       **SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.**

7       (a) PRIMARY CARE.—If a group health plan, or a  
8       health insurance issuer that offers health insurance cov-  
9       erage, requires or provides for designation by a partici-  
10      pant, beneficiary, or enrollee of a participating primary  
11      care provider, then the plan or issuer shall permit each  
12      participant, beneficiary, and enrollee to designate any par-  
13      ticipating primary care provider who is available to accept  
14      such individual.

15      (b) SPECIALISTS.—

16           (1) IN GENERAL.—Subject to paragraph (2), a  
17      group health plan and a health insurance issuer that  
18      offers health insurance coverage shall permit each  
19      participant, beneficiary, or enrollee to receive medi-  
20      cally necessary and appropriate specialty care, pur-  
21      suant to appropriate referral procedures, from any  
22      qualified participating health care professional who  
23      is available to accept such individual for such care.

24           (2) LIMITATION.—Paragraph (1) shall not  
25      apply to specialty care if the plan or issuer clearly

1 informs participants, beneficiaries, and enrollees of  
2 the limitations on choice of participating health care  
3 professionals with respect to such care.

4 (3) CONSTRUCTION.—Nothing in this sub-  
5 section shall be construed as affecting the applica-  
6 tion of section 114 (relating to timely access to spe-  
7 cialists).

8 **SEC. 113. ACCESS TO EMERGENCY CARE.**

9 (a) COVERAGE OF EMERGENCY SERVICES.—

10 (1) IN GENERAL.—If a group health plan, or  
11 health insurance coverage offered by a health insur-  
12 ance issuer, provides or covers any benefits with re-  
13 spect to services in an emergency department of a  
14 hospital, the plan or issuer shall cover emergency  
15 services (as defined in paragraph (2)(B))—

16 (A) without the need for any prior author-  
17 ization determination;

18 (B) whether the health care provider fur-  
19 nishing such services is a participating provider  
20 with respect to such services;

21 (C) in a manner so that, if such services  
22 are provided to a participant, beneficiary, or  
23 enrollee—

1 (i) by a nonparticipating health care  
 2 provider with or without prior authoriza-  
 3 tion, or

4 (ii) by a participating health care pro-  
 5 vider without prior authorization,  
 6 the participant, beneficiary, or enrollee is not  
 7 liable for amounts that exceed the amounts of  
 8 liability that would be incurred if the services  
 9 were provided by a participating health care  
 10 provider with prior authorization; and

11 (D) without regard to any other term or  
 12 condition of such coverage (other than exclusion  
 13 or coordination of benefits, or an affiliation or  
 14 waiting period, permitted under section 2701 of  
 15 the Public Health Service Act, section 701 of  
 16 the Employee Retirement Income Security Act  
 17 of 1974, or section 9801 of the Internal Rev-  
 18 enue Code of 1986, and other than applicable  
 19 cost-sharing).

20 (2) DEFINITIONS.—In this section:

21 (A) EMERGENCY MEDICAL CONDITION.—  
 22 The term “emergency medical condition” means  
 23 a medical condition manifesting itself by acute  
 24 symptoms of sufficient severity (including se-  
 25 vere pain) such that a prudent layperson, who

1 possesses an average knowledge of health and  
2 medicine, could reasonably expect the absence  
3 of immediate medical attention to result in a  
4 condition described in clause (i), (ii), or (iii) of  
5 section 1867(e)(1)(A) of the Social Security  
6 Act.

7 (B) EMERGENCY SERVICES.—The term  
8 “emergency services” means, with respect to an  
9 emergency medical condition—

10 (i) a medical screening examination  
11 (as required under section 1867 of the So-  
12 cial Security Act) that is within the capa-  
13 bility of the emergency department of a  
14 hospital, including ancillary services rou-  
15 tinely available to the emergency depart-  
16 ment to evaluate such emergency medical  
17 condition, and

18 (ii) within the capabilities of the staff  
19 and facilities available at the hospital, such  
20 further medical examination and treatment  
21 as are required under section 1867 of such  
22 Act to stabilize the patient.

23 (C) STABILIZE.—The term “to stabilize”,  
24 with respect to an emergency medical condition  
25 (as defined in subparagraph (A)), has the

1 meaning given in section 1867(e)(3) of the So-  
2 cial Security Act (42 U.S.C. 1395dd(e)(3)).

3 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND  
4 POST-STABILIZATION CARE.—A group health plan, and  
5 health insurance coverage offered by a health insurance  
6 issuer, must provide reimbursement for maintenance care  
7 and post-stabilization care in accordance with the require-  
8 ments of section 1852(d)(2) of the Social Security Act (42  
9 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be  
10 provided in a manner consistent with subsection (a)(1)(C).

11 (c) COVERAGE OF EMERGENCY AMBULANCE SERV-  
12 ICES.—

13 (1) IN GENERAL.—If a group health plan, or  
14 health insurance coverage provided by a health in-  
15 surance issuer, provides any benefits with respect to  
16 ambulance services and emergency services, the plan  
17 or issuer shall cover emergency ambulance services  
18 (as defined in paragraph (2)) furnished under the  
19 plan or coverage under the same terms and condi-  
20 tions under subparagraphs (A) through (D) of sub-  
21 section (a)(1) under which coverage is provided for  
22 emergency services.

23 (2) EMERGENCY AMBULANCE SERVICES.—For  
24 purposes of this subsection, the term “emergency  
25 ambulance services” means ambulance services (as

1 defined for purposes of section 1861(s)(7) of the So-  
2 cial Security Act) furnished to transport an indi-  
3 vidual who has an emergency medical condition (as  
4 defined in subsection (a)(2)(A)) to a hospital for the  
5 receipt of emergency services (as defined in sub-  
6 section (a)(2)(B)) in a case in which the emergency  
7 services are covered under the plan or coverage pur-  
8 suant to subsection (a)(1) and a prudent layperson,  
9 with an average knowledge of health and medicine,  
10 could reasonably expect that the absence of such  
11 transport would result in placing the health of the  
12 individual in serious jeopardy, serious impairment of  
13 bodily function, or serious dysfunction of any bodily  
14 organ or part.

15 **SEC. 114. TIMELY ACCESS TO SPECIALISTS.**

16 (a) TIMELY ACCESS.—

17 (1) IN GENERAL.—A group health plan and a  
18 health insurance issuer offering health insurance  
19 coverage shall ensure that participants, beneficiaries,  
20 and enrollees receive timely access to specialists who  
21 are appropriate to the condition of, and accessible  
22 to, the participant, beneficiary, or enrollee, when  
23 such specialty care is a covered benefit under the  
24 plan or coverage.



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

3           (A) to require the coverage under a group  
4 health plan or health insurance coverage of ben-  
5 efits or services;

6           (B) to prohibit a plan or issuer from in-  
7 cluding providers in the network only to the ex-  
8 tent necessary to meet the needs of the plan’s  
9 or issuer’s participants, beneficiaries, or enroll-  
10 ees; or

11          (C) to override any State licensure or  
12 scope-of-practice law.

13       (3) ACCESS TO CERTAIN PROVIDERS.—

14           (A) IN GENERAL.—With respect to spe-  
15 cialty care under this section, if a participating  
16 specialist is not available and qualified to pro-  
17 vide such care to the participant, beneficiary, or  
18 enrollee, the plan or issuer shall provide for cov-  
19 erage of such care by a nonparticipating spe-  
20 cialist.

21           (B) TREATMENT OF NONPARTICIPATING  
22 PROVIDERS.—If a participant, beneficiary, or  
23 enrollee receives care from a nonparticipating  
24 specialist pursuant to subparagraph (A), such  
25 specialty care shall be provided at no additional

1 cost to the participant, beneficiary, or enrollee  
2 beyond what the participant, beneficiary, or en-  
3 rollee would otherwise pay for such specialty  
4 care if provided by a participating specialist.

5 (b) REFERRALS.—

6 (1) AUTHORIZATION.—Subject to subsection  
7 (a)(1), a group health plan or health insurance  
8 issuer may require an authorization in order to ob-  
9 tain coverage for specialty services under this sec-  
10 tion. Any such authorization—

11 (A) shall be for an appropriate duration of  
12 time or number of referrals, including an au-  
13 thorization for a standing referral where appro-  
14 priate; and

15 (B) may not be refused solely because the  
16 authorization involves services of a nonpartici-  
17 pating specialist (described in subsection  
18 (a)(3)).

19 (2) REFERRALS FOR ONGOING SPECIAL CONDI-  
20 TIONS.—

21 (A) IN GENERAL.—Subject to subsection  
22 (a)(1), a group health plan and a health insur-  
23 ance issuer shall permit a participant, bene-  
24 ficiary, or enrollee who has an ongoing special  
25 condition (as defined in subparagraph (B)) to

1 receive a referral to a specialist for the treat-  
2 ment of such condition and such specialist may  
3 authorize such referrals, procedures, tests, and  
4 other medical services with respect to such con-  
5 dition, or coordinate the care for such condi-  
6 tion, subject to the terms of a treatment plan  
7 (if any) referred to in subsection (c) with re-  
8 spect to the condition.

9 (B) ONGOING SPECIAL CONDITION DE-  
10 FINED.—In this subsection, the term “ongoing  
11 special condition” means a condition or disease  
12 that—

13 (i) is life-threatening, degenerative,  
14 potentially disabling, or congenital; and

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

17 (c) TREATMENT PLANS.—

18 (1) IN GENERAL.—A group health plan or  
19 health insurance issuer may require that the spe-  
20 cialty care be provided—

21 (A) pursuant to a treatment plan, but only  
22 if the treatment plan—

23 (i) is developed by the specialist, in  
24 consultation with the case manager or pri-

1           mary care provider, and the participant,  
2           beneficiary, or enrollee, and

3                   (ii) is approved by the plan or issuer  
4           in a timely manner, if the plan or issuer  
5           requires such approval; and

6                   (B) in accordance with applicable quality  
7           assurance and utilization review standards of  
8           the plan or issuer.

9           (2) NOTIFICATION.—Nothing in paragraph (1)  
10          shall be construed as prohibiting a plan or issuer  
11          from requiring the specialist to provide the plan or  
12          issuer with regular updates on the specialty care  
13          provided, as well as all other reasonably necessary  
14          medical information.

15          (d) SPECIALIST DEFINED.—For purposes of this sec-  
16          tion, the term “specialist” means, with respect to the con-  
17          dition of the participant, beneficiary, or enrollee, a health  
18          care professional, facility, or center that has adequate ex-  
19          pertise through appropriate training and experience (in-  
20          cluding, in the case of a child, appropriate pediatric exper-  
21          tise) to provide high quality care in treating the condition.

22       **SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECO-**  
23       **LOGICAL CARE.**

24          (a) GENERAL RIGHTS.—

1           (1) DIRECT ACCESS.—A group health plan, and  
2           a health insurance issuer offering health insurance  
3           coverage, described in subsection (b) may not re-  
4           quire authorization or referral by the plan, issuer, or  
5           any person (including a primary care provider de-  
6           scribed in subsection (b)(2)) in the case of a female  
7           participant, beneficiary, or enrollee who seeks cov-  
8           erage for obstetrical or gynecological care provided  
9           by a participating health care professional who spe-  
10          cializes in obstetrics or gynecology.

11          (2) OBSTETRICAL AND GYNECOLOGICAL  
12          CARE.—A group health plan and a health insurance  
13          issuer described in subsection (b) shall treat the pro-  
14          vision of obstetrical and gynecological care, and the  
15          ordering of related obstetrical and gynecological  
16          items and services, pursuant to the direct access de-  
17          scribed under paragraph (1), by a participating  
18          health care professional who specializes in obstetrics  
19          or gynecology as the authorization of the primary  
20          care provider.

21          (b) APPLICATION OF SECTION.—A group health plan,  
22          or health insurance issuer offering health insurance cov-  
23          erage, described in this subsection is a group health plan  
24          or coverage that—

1           (1) provides coverage for obstetric or  
2       gynecologic care; and

3           (2) requires the designation by a participant,  
4       beneficiary, or enrollee of a participating primary  
5       care provider.

6       (c) CONSTRUCTION.—Nothing in subsection (a) shall  
7       be construed to—

8           (1) waive any exclusions of coverage under the  
9       terms and conditions of the plan or health insurance  
10      coverage with respect to coverage of obstetrical or  
11      gynecological care; or

12          (2) preclude the group health plan or health in-  
13      surance issuer involved from requiring that the ob-  
14      stetrical or gynecological provider notify the primary  
15      care health care professional or the plan or issuer of  
16      treatment decisions.

17   **SEC. 116. ACCESS TO PEDIATRIC CARE.**

18       (a) PEDIATRIC CARE.—In the case of a person who  
19      has a child who is a participant, beneficiary, or enrollee  
20      under a group health plan, or health insurance coverage  
21      offered by a health insurance issuer, if the plan or issuer  
22      requires or provides for the designation of a participating  
23      primary care provider for the child, the plan or issuer shall  
24      permit such person to designate a physician (allopathic or  
25      osteopathic) who specializes in pediatrics as the child's pri-

1    mary care provider if such provider participates in the net-  
2    work of the plan or issuer.

3           (b) CONSTRUCTION.—Nothing in subsection (a) shall  
4    be construed to waive any exclusions of coverage under  
5    the terms and conditions of the plan or health insurance  
6    coverage with respect to coverage of pediatric care.

7    **SEC. 117. CONTINUITY OF CARE.**

8           (a) TERMINATION OF PROVIDER.—

9               (1) IN GENERAL.—If—

10                   (A) a contract between a group health  
11                   plan, or a health insurance issuer offering  
12                   health insurance coverage, and a treating health  
13                   care provider is terminated (as defined in para-  
14                   graph (e)(4)); or

15                   (B) benefits or coverage provided by a  
16                   health care provider are terminated because of  
17                   a change in the terms of provider participation  
18                   in such plan or coverage,

19           the plan or issuer shall meet the requirements of  
20           paragraph (3) with respect to each continuing care  
21           patient.

22               (2) TREATMENT OF TERMINATION OF CON-  
23               TRACT WITH HEALTH INSURANCE ISSUER.—If a  
24               contract for the provision of health insurance cov-  
25               erage between a group health plan and a health in-

1       surance issuer is terminated and, as a result of such  
2       termination, coverage of services of a health care  
3       provider is terminated with respect to an individual,  
4       the provisions of paragraph (1) (and the succeeding  
5       provisions of this section) shall apply under the plan  
6       in the same manner as if there had been a contract  
7       between the plan and the provider that had been ter-  
8       minated, but only with respect to benefits that are  
9       covered under the plan after the contract termi-  
10      nation.

11           (3) REQUIREMENTS.—The requirements of this  
12      paragraph are that the plan or issuer—

13           (A) notify the continuing care patient in-  
14      volved, or arrange to have the patient notified  
15      pursuant to subsection (d)(2), on a timely basis  
16      of the termination described in paragraph (1)  
17      (or paragraph (2), if applicable) and the right  
18      to elect continued transitional care from the  
19      provider under this section;

20           (B) provide the patient with an oppor-  
21      tunity to notify the plan or issuer of the pa-  
22      tient's need for transitional care; and

23           (C) subject to subsection (c), permit the  
24      patient to elect to continue to be covered with  
25      respect to the course of treatment by such pro-



1           vider with the provider’s consent during a tran-  
2           sitional period (as provided for under subsection  
3           (b)).

4           (4) CONTINUING CARE PATIENT.—For purposes  
5           of this section, the term “continuing care patient”  
6           means a participant, beneficiary, or enrollee who—

7                   (A) is undergoing a course of treatment  
8                   for a serious and complex condition from the  
9                   provider at the time the plan or issuer receives  
10                  or provides notice of provider, benefit, or cov-  
11                  erage termination described in paragraph (1)  
12                  (or paragraph (2), if applicable);

13                  (B) is undergoing a course of institutional  
14                  or inpatient care from the provider at the time  
15                  of such notice;

16                  (C) is scheduled to undergo non-elective  
17                  surgery from the provider at the time of such  
18                  notice;

19                  (D) is pregnant and undergoing a course  
20                  of treatment for the pregnancy from the pro-  
21                  vider at the time of such notice; or

22                  (E) is or was determined to be terminally  
23                  ill (as determined under section 1861(dd)(3)(A)  
24                  of the Social Security Act) at the time of such  
25                  notice, but only with respect to a provider that

1           was treating the terminal illness before the date  
2           of such notice.

3       (b) TRANSITIONAL PERIODS.—

4           (1) SERIOUS AND COMPLEX CONDITIONS.—The  
5       transitional period under this subsection with re-  
6       spect to a continuing care patient described in sub-  
7       section (a)(4)(A) shall extend for up to 90 days (as  
8       determined by the treating health care professional)  
9       from the date of the notice described in subsection  
10      (a)(3)(A).

11          (2) INSTITUTIONAL OR INPATIENT CARE.—The  
12      transitional period under this subsection for a con-  
13      tinuing care patient described in subsection  
14      (a)(4)(B) shall extend until the earlier of—

15            (A) the expiration of the 90-day period be-  
16            ginning on the date on which the notice under  
17            subsection (a)(3)(A) is provided; or

18            (B) the date of discharge of the patient  
19            from such care or the termination of the period  
20            of institutionalization, or, if later, the date of  
21            completion of reasonable follow-up care.

22          (3) SCHEDULED NON-ELECTIVE SURGERY.—  
23      The transitional period under this subsection for a  
24      continuing care patient described in subsection  
25      (a)(4)(C) shall extend until the completion of the

1 surgery involved and post-surgical follow-up care re-  
2 lating to the surgery and occurring within 90 days  
3 after the date of the surgery.

4 (4) PREGNANCY.—The transitional period  
5 under this subsection for a continuing care patient  
6 described in subsection (a)(4)(D) shall extend  
7 through the provision of post-partum care directly  
8 related to the delivery.

9 (5) TERMINAL ILLNESS.—The transitional pe-  
10 riod under this subsection for a continuing care pa-  
11 tient described in subsection (a)(4)(E) shall extend  
12 for the remainder of the patient's life for care that  
13 is directly related to the treatment of the terminal  
14 illness or its medical manifestations.

15 (c) PERMISSIBLE TERMS AND CONDITIONS.—A  
16 group health plan or health insurance issuer may condi-  
17 tion coverage of continued treatment by a provider under  
18 this section upon the provider agreeing to the following  
19 terms and conditions:

20 (1) The treating health care provider agrees to  
21 accept reimbursement from the plan or issuer and  
22 continuing care patient involved (with respect to  
23 cost-sharing) at the rates applicable prior to the  
24 start of the transitional period as payment in full  
25 (or, in the case described in subsection (a)(2), at the

1 rates applicable under the replacement plan or cov-  
2 erage after the date of the termination of the con-  
3 tract with the group health plan or health insurance  
4 issuer) and not to impose cost-sharing with respect  
5 to the patient in an amount that would exceed the  
6 cost-sharing that could have been imposed if the  
7 contract referred to in subsection (a)(1) had not  
8 been terminated.

9 (2) The treating health care provider agrees to  
10 adhere to the quality assurance standards of the  
11 plan or issuer responsible for payment under para-  
12 graph (1) and to provide to such plan or issuer nec-  
13 essary medical information related to the care pro-  
14 vided.

15 (3) The treating health care provider agrees  
16 otherwise to adhere to such plan's or issuer's policies  
17 and procedures, including procedures regarding re-  
18 ferrals and obtaining prior authorization and pro-  
19 viding services pursuant to a treatment plan (if any)  
20 approved by the plan or issuer.

21 (d) RULES OF CONSTRUCTION.—Nothing in this sec-  
22 tion shall be construed—

23 (1) to require the coverage of benefits which  
24 would not have been covered if the provider involved  
25 remained a participating provider; or

1           (2) with respect to the termination of a con-  
2           tract under subsection (a) to prevent a group health  
3           plan or health insurance issuer from requiring that  
4           the health care provider—

5                   (A) notify participants, beneficiaries, or en-  
6                   rollees of their rights under this section; or

7                   (B) provide the plan or issuer with the  
8                   name of each participant, beneficiary, or en-  
9                   rollee who the provider believes is a continuing  
10                  care patient.

11       (e) DEFINITIONS.—In this section:

12           (1) CONTRACT.—The term “contract” includes,  
13           with respect to a plan or issuer and a treating  
14           health care provider, a contract between such plan  
15           or issuer and an organized network of providers that  
16           includes the treating health care provider, and (in  
17           the case of such a contract) the contract between the  
18           treating health care provider and the organized net-  
19           work.

20           (2) HEALTH CARE PROVIDER.—The term  
21           “health care provider” or “provider” means—

22                   (A) any individual who is engaged in the  
23                   delivery of health care services in a State and  
24                   who is required by State law or regulation to be

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

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

9 (3) SERIOUS AND COMPLEX CONDITION.—The  
10 term “serious and complex condition” means, with  
11 respect to a participant, beneficiary, or enrollee  
12 under the plan or coverage—

13 (A) in the case of an acute illness, a condi-  
14 tion that is serious enough to require special-  
15 ized medical treatment to avoid the reasonable  
16 possibility of death or permanent harm; or

17 (B) in the case of a chronic illness or con-  
18 dition, is an ongoing special condition (as de-  
19 fined in section 114(b)(2)(B)).

20 (4) TERMINATED.—The term “terminated” in-  
21 cludes, with respect to a contract, the expiration or  
22 nonrenewal of the contract, but does not include a  
23 termination of the contract for failure to meet appli-  
24 cable quality standards or for fraud.

1 **SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

2 (a) IN GENERAL.—To the extent that a group health  
3 plan, or health insurance coverage offered by a health in-  
4 surance issuer, provides coverage for benefits with respect  
5 to prescription drugs, and limits such coverage to drugs  
6 included in a formulary, the plan or issuer shall—

7 (1) ensure the participation of physicians and  
8 pharmacists in developing and reviewing such for-  
9 mulary;

10 (2) provide for disclosure of the formulary to  
11 providers; and

12 (3) in accordance with the applicable quality as-  
13 surance and utilization review standards of the plan  
14 or issuer, provide for exceptions from the formulary  
15 limitation when a non-formulary alternative is medi-  
16 cally necessary and appropriate and, in the case of  
17 such an exception, apply the same cost-sharing re-  
18 quirements that would have applied in the case of a  
19 drug covered under the formulary.

20 (b) COVERAGE OF APPROVED DRUGS AND MEDICAL  
21 DEVICES.—

22 (1) IN GENERAL.—A group health plan (and  
23 health insurance coverage offered in connection with  
24 such a plan) that provides any coverage of prescrip-  
25 tion drugs or medical devices shall not deny coverage

1 of such a drug or device on the basis that the use  
2 is investigational, if the use—

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

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

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

17 (B) in the case of a medical device, is in-  
18 cluded in the labeling authorized by a regula-  
19 tion under subsection (d) or (e) of section 513  
20 of the Federal Food, Drug, and Cosmetic Act,  
21 an order under subsection (f) of such section, or  
22 an application approved under section 515 of  
23 such Act, without regard to any postmarketing  
24 requirements that may apply under such Act.



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

6   **SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**  
7                           **APPROVED CLINICAL TRIALS.**

8           (a) COVERAGE.—

9           (1) IN GENERAL.—If a group health plan, or  
10          health insurance issuer that is providing health in-  
11          surance coverage, provides coverage to a qualified in-  
12          dividual (as defined in subsection (b)), the plan or  
13          issuer—

14                 (A) may not deny the individual partici-  
15          pation in the clinical trial referred to in subsection  
16          (b)(2);

17                 (B) subject to subsection (c), may not deny  
18          (or limit or impose additional conditions on) the  
19          coverage of routine patient costs for items and  
20          services furnished in connection with participa-  
21          tion in the trial; and

22                 (C) may not discriminate against the indi-  
23          vidual on the basis of the enrollee's participa-  
24          tion in such trial.

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

6           (3) USE OF IN-NETWORK PROVIDERS.—If one  
7       or more participating providers is participating in a  
8       clinical trial, nothing in paragraph (1) shall be con-  
9       strued as preventing a plan or issuer from requiring  
10      that a qualified individual participate in the trial  
11      through such a participating provider if the provider  
12      will accept the individual as a participant in the  
13      trial.

14      (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-  
15      poses of subsection (a), the term “qualified individual”  
16      means an individual who is a participant or beneficiary  
17      in a group health plan, or who is an enrollee under health  
18      insurance coverage, and who meets the following condi-  
19      tions:

20           (1)(A) The individual has a life-threatening or  
21      serious illness for which no standard treatment is ef-  
22      fective.

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

1           (C) The individual's participation in the trial  
2           offers meaningful potential for significant clinical  
3           benefit for the individual.

4           (2) Either—

5                 (A) the referring physician is a partici-  
6                 pating health care professional and has con-  
7                 cluded that the individual's participation in  
8                 such trial would be appropriate based upon the  
9                 individual meeting the conditions described in  
10                paragraph (1); or

11               (B) the participant, beneficiary, or enrollee  
12               provides medical and scientific information es-  
13               tablishing that the individual's participation in  
14               such trial would be appropriate based upon the  
15               individual meeting the conditions described in  
16               paragraph (1).

17       (c) PAYMENT.—

18           (1) IN GENERAL.—Under this section a group  
19           health plan and a health insurance issuer shall pro-  
20           vide for payment for routine patient costs described  
21           in subsection (a)(2) but is not required to pay for  
22           costs of items and services that are reasonably ex-  
23           pected (as determined by the appropriate Secretary)  
24           to be paid for by the sponsors of an approved clin-  
25           ical trial.

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

3           (A) a participating provider, the payment  
4 rate shall be at the agreed upon rate; or

5           (B) a nonparticipating provider, the pay-  
6 ment rate shall be at the rate the plan or issuer  
7 would normally pay for comparable services  
8 under subparagraph (A).

9       (d) APPROVED CLINICAL TRIAL DEFINED.—

10           (1) IN GENERAL.—In this section, the term  
11 “approved clinical trial” means a clinical research  
12 study or clinical investigation—

13           (A) approved and funded (which may in-  
14 clude funding through in-kind contributions) by  
15 one or more of the following:

16                   (i) the National Institutes of Health;

17                   (ii) a cooperative group or center of  
18 the National Institutes of Health, includ-  
19 ing a qualified nongovernmental research  
20 entity to which the National Cancer Insti-  
21 tute has awarded a center support grant;

22                   (iii) either of the following if the con-  
23 ditions described in paragraph (2) are  
24 met—

1 (I) the Department of Veterans  
2 Affairs;

3 (II) the Department of Defense;  
4 or

5 (B) approved by the Food and Drug Ad-  
6 ministration.

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

13 (A) to be comparable to the system of peer  
14 review of studies and investigations used by the  
15 National Institutes of Health; and

16 (B) assures unbiased review of the highest  
17 ethical standards by qualified individuals who  
18 have no interest in the outcome of the review.

19 (e) CONSTRUCTION.—Nothing in this section shall be  
20 construed to limit a plan's or issuer's coverage with re-  
21 spect to clinical trials.

1 **SEC. 120. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
2 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
3 **DISSECTIONS FOR THE TREATMENT OF**  
4 **BREAST CANCER AND COVERAGE FOR SEC-**  
5 **ONDARY CONSULTATIONS.**

6 (a) INPATIENT CARE.—

7 (1) IN GENERAL.—A group health plan, and a  
8 health insurance issuer providing health insurance  
9 coverage, that provides medical and surgical benefits  
10 shall ensure that inpatient coverage with respect to  
11 the treatment of breast cancer is provided for a pe-  
12 riod of time as is determined by the attending physi-  
13 cian, in consultation with the patient, to be medi-  
14 cally necessary and appropriate following—

15 (A) a mastectomy;

16 (B) a lumpectomy; or

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

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

24 (b) PROHIBITION ON CERTAIN MODIFICATIONS.—In  
25 implementing the requirements of this section, a group  
26 health plan, and a health insurance issuer providing health

1 insurance coverage, may not modify the terms and condi-  
2 tions of coverage based on the determination by a partici-  
3 pant, beneficiary, or enrollee to request less than the min-  
4 imum coverage required under subsection (a).

5 (c) SECONDARY CONSULTATIONS.—

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

1 consultation with any other specialist selected by the  
2 attending physician for such purpose at no addi-  
3 tional cost to the individual beyond that which the  
4 individual would have paid if the specialist was par-  
5 ticipating in the network of the plan or issuer.

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

10 (d) PROHIBITION ON PENALTIES OR INCENTIVES.—  
11 A group health plan, and a health insurance issuer pro-  
12 viding health insurance coverage, may not—

13 (1) penalize or otherwise reduce or limit the re-  
14 imbursement of a provider or specialist because the  
15 provider or specialist provided care to a participant,  
16 beneficiary, or enrollee in accordance with this sec-  
17 tion;

18 (2) provide financial or other incentives to a  
19 physician or specialist to induce the physician or  
20 specialist to keep the length of inpatient stays of pa-  
21 tients following a mastectomy, lumpectomy, or a  
22 lymph node dissection for the treatment of breast  
23 cancer below certain limits or to limit referrals for  
24 secondary consultations; or



1           (3) provide financial or other incentives to a  
 2           physician or specialist to induce the physician or  
 3           specialist to refrain from referring a participant,  
 4           beneficiary, or enrollee for a secondary consultation  
 5           that would otherwise be covered by the plan or cov-  
 6           erage involved under subsection (c).

## 7       **Subtitle C—Access to Information**

### 8       **SEC. 121. PATIENT ACCESS TO INFORMATION.**

9           (a) REQUIREMENT.—

10          (1) DISCLOSURE.—

11               (A) IN GENERAL.—A group health plan,  
 12               and a health insurance issuer that provides cov-  
 13               erage in connection with health insurance cov-  
 14               erage, shall provide for the disclosure to partici-  
 15               pants, beneficiaries, and enrollees—

16                       (i) of the information described in  
 17                       subsection (b) at the time of the initial en-  
 18                       rollment of the participant, beneficiary, or  
 19                       enrollee under the plan or coverage;

20                       (ii) of such information on an annual  
 21                       basis—

22                               (I) in conjunction with the elec-  
 23                               tion period of the plan or coverage if  
 24                               the plan or coverage has such an elec-  
 25                               tion period; or

1 (II) in the case of a plan or cov-  
2 erage that does not have an election  
3 period, in conjunction with the begin-  
4 ning of the plan or coverage year; and  
5 (iii) of information relating to any  
6 material reduction to the benefits or infor-  
7 mation described in such subsection or  
8 subsection (c), in the form of a notice pro-  
9 vided not later than 30 days before the  
10 date on which the reduction takes effect.

11 (B) PARTICIPANTS, BENEFICIARIES, AND  
12 ENROLLEES.—The disclosure required under  
13 subparagraph (A) shall be provided—

14 (i) jointly to each participant, bene-  
15 ficiary, and enrollee who reside at the same  
16 address; or

17 (ii) in the case of a beneficiary or en-  
18 rollee who does not reside at the same ad-  
19 dress as the participant or another en-  
20 rollee, separately to the participant or  
21 other enrollees and such beneficiary or en-  
22 rollee.

23 (2) PROVISION OF INFORMATION.—Information  
24 shall be provided to participants, beneficiaries, and  
25 enrollees under this section at the last known ad-

1 dress maintained by the plan or issuer with respect  
2 to such participants, beneficiaries, or enrollees, to  
3 the extent that such information is provided to par-  
4 ticipants, beneficiaries, or enrollees via the United  
5 States Postal Service or other private delivery serv-  
6 ice.

7 (b) REQUIRED INFORMATION.—The informational  
8 materials to be distributed under this section shall include  
9 for each option available under the group health plan or  
10 health insurance coverage the following:

11 (1) BENEFITS.—A description of the covered  
12 benefits, including—

13 (A) any in- and out-of-network benefits;

14 (B) specific preventive services covered  
15 under the plan or coverage if such services are  
16 covered;

17 (C) any specific exclusions or express limi-  
18 tations of benefits described in section  
19 503C(d)(3)(C) of the Bipartisan Patient Pro-  
20 tection Act;

21 (D) any other benefit limitations, including  
22 any annual or lifetime benefit limits and any  
23 monetary limits or limits on the number of vis-  
24 its, days, or services, and any specific coverage  
25 exclusions; and

1           (E) any definition of medical necessity  
2           used in making coverage determinations by the  
3           plan, issuer, or claims administrator.

4           (2) COST SHARING.—A description of any cost-  
5           sharing requirements, including—

6                (A) any premiums, deductibles, coinsur-  
7                ance, copayment amounts, and liability for bal-  
8                ance billing, for which the participant, bene-  
9                ficiary, or enrollee will be responsible under  
10              each option available under the plan;

11              (B) any maximum out-of-pocket expense  
12              for which the participant, beneficiary, or en-  
13              rollee may be liable;

14              (C) any cost-sharing requirements for out-  
15              of-network benefits or services received from  
16              nonparticipating providers; and

17              (D) any additional cost-sharing or charges  
18              for benefits and services that are furnished  
19              without meeting applicable plan or coverage re-  
20              quirements, such as prior authorization or  
21              precertification.

22           (3) DISENROLLMENT.—Information relating to  
23           the disenrollment of a participant, beneficiary, or en-  
24           rollee.

1           (4) SERVICE AREA.—A description of the plan  
2           or issuer's service area, including the provision of  
3           any out-of-area coverage.

4           (5) PARTICIPATING PROVIDERS.—A directory of  
5           participating providers (to the extent a plan or  
6           issuer provides coverage through a network of pro-  
7           viders) that includes, at a minimum, the name, ad-  
8           dress, and telephone number of each participating  
9           provider, and information about how to inquire  
10          whether a participating provider is currently accept-  
11          ing new patients.

12          (6) CHOICE OF PRIMARY CARE PROVIDER.—A  
13          description of any requirements and procedures to  
14          be used by participants, beneficiaries, and enrollees  
15          in selecting, accessing, or changing their primary  
16          care provider, including providers both within and  
17          outside of the network (if the plan or issuer permits  
18          out-of-network services), and the right to select a pe-  
19          diatrician as a primary care provider under section  
20          116 for a participant, beneficiary, or enrollee who is  
21          a child if such section applies.

22          (7) PREAUTHORIZATION REQUIREMENTS.—A  
23          description of the requirements and procedures to be  
24          used to obtain preauthorization for health services,  
25          if such preauthorization is required.

1           (8) EXPERIMENTAL AND INVESTIGATIONAL  
2       TREATMENTS.—A description of the process for de-  
3       termining whether a particular item, service, or  
4       treatment is considered experimental or investiga-  
5       tional, and the circumstances under which such  
6       treatments are covered by the plan or issuer.

7           (9) SPECIALTY CARE.—A description of the re-  
8       quirements and procedures to be used by partici-  
9       pants, beneficiaries, and enrollees in accessing spe-  
10      cialty care and obtaining referrals to participating  
11      and nonparticipating specialists, including any limi-  
12      tations on choice of health care professionals re-  
13      ferred to in section 112(b)(2) and the right to timely  
14      access to specialists care under section 114 if such  
15      section applies.

16          (10) CLINICAL TRIALS.—A description of the  
17      circumstances and conditions under which participa-  
18      tion in clinical trials is covered under the terms and  
19      conditions of the plan or coverage, and the right to  
20      obtain coverage for approved clinical trials under  
21      section 119 if such section applies.

22          (11) PRESCRIPTION DRUGS.—To the extent the  
23      plan or issuer provides coverage for prescription  
24      drugs, a statement of whether such coverage is lim-  
25      ited to drugs included in a formulary, a description

1 of any provisions and cost-sharing required for ob-  
2 taining on- and off-formulary medications, and a de-  
3 scription of the rights of participants, beneficiaries,  
4 and enrollees in obtaining access to access to pre-  
5 scription drugs under section 118 if such section ap-  
6 plies.

7 (12) EMERGENCY SERVICES.—A summary of  
8 the rules and procedures for accessing emergency  
9 services, including the right of a participant, bene-  
10 ficiary, or enrollee to obtain emergency services  
11 under the prudent layperson standard under section  
12 113, if such section applies, and any educational in-  
13 formation that the plan or issuer may provide re-  
14 garding the appropriate use of emergency services.

15 (13) CLAIMS AND APPEALS.—A description of  
16 the plan or issuer's rules and procedures pertaining  
17 to claims and appeals, a description of the rights  
18 (including deadlines for exercising rights) of partici-  
19 pants, beneficiaries, and enrollees under subtitle A  
20 in obtaining covered benefits, filing a claim for bene-  
21 fits, and appealing coverage decisions internally and  
22 externally (including telephone numbers and mailing  
23 addresses of the appropriate authority), and a de-  
24 scription of any additional legal rights and remedies  
25 available under section 502 of the Employee Retire-

1       ment Income Security Act of 1974 and applicable  
2       State law.

3               (14) ADVANCE DIRECTIVES AND ORGAN DONA-  
4       TION.—A description of procedures for advance di-  
5       rectives and organ donation decisions if the plan or  
6       issuer maintains such procedures.

7               (15) INFORMATION ON PLANS AND ISSUERS.—  
8       The name, mailing address, and telephone number  
9       or numbers of the plan administrator and the issuer  
10      to be used by participants, beneficiaries, and enroll-  
11      ees seeking information about plan or coverage bene-  
12      fits and services, payment of a claim, or authoriza-  
13      tion for services and treatment. Notice of whether  
14      the benefits under the plan or coverage are provided  
15      under a contract or policy of insurance issued by an  
16      issuer, or whether benefits are provided directly by  
17      the plan sponsor who bears the insurance risk.

18              (16) TRANSLATION SERVICES.—A summary de-  
19      scription of any translation or interpretation services  
20      (including the availability of printed information in  
21      languages other than English, audio tapes, or infor-  
22      mation in Braille) that are available for non-English  
23      speakers and participants, beneficiaries, and enroll-  
24      ees with communication disabilities and a description  
25      of how to access these items or services.



1           (17) ACCREDITATION INFORMATION.—Any in-  
2           formation that is made public by accrediting organi-  
3           zations in the process of accreditation if the plan or  
4           issuer is accredited, or any additional quality indica-  
5           tors (such as the results of enrollee satisfaction sur-  
6           veys) that the plan or issuer makes public or makes  
7           available to participants, beneficiaries, and enrollees.

8           (18) NOTICE OF REQUIREMENTS.—A descrip-  
9           tion of any rights of participants, beneficiaries, and  
10          enrollees that are established by the provisions of  
11          this Act (excluding those described in paragraphs  
12          (1) through (17)) and of the amendments made  
13          thereby if such provisions apply. The description re-  
14          quired under this paragraph may be combined with  
15          the notices of the type described in sections 711(d),  
16          713(b), or 606(a)(1) of the Employee Retirement  
17          Income Security Act of 1974 and with any other no-  
18          tice provision that the appropriate Secretary deter-  
19          mines may be combined, so long as such combina-  
20          tion does not result in any reduction in the informa-  
21          tion that would otherwise be provided to the recipi-  
22          ent.

23          (19) AVAILABILITY OF ADDITIONAL INFORMA-  
24          TION.—A statement that the information described  
25          in subsection (c), and instructions on obtaining such

1 information (including telephone numbers and, if  
2 available, Internet websites), shall be made available  
3 upon request.

4 (20) DESIGNATED DECISIONMAKERS.—The  
5 name and address of the designated decisionmaker  
6 (or decisionmakers) appointed under paragraph (2)  
7 of section 502(n) of the Employee Retirement In-  
8 come Security Act of 1974 for purposes of such sec-  
9 tion and a description of the participants and bene-  
10 ficiaries with respect to whom each designated deci-  
11 sionmaker under the plan has assumed liability  
12 under section 502(n) of such Act.

13 (c) ADDITIONAL INFORMATION.—The informational  
14 materials to be provided upon the request of a participant,  
15 beneficiary, or enrollee shall include for each option avail-  
16 able under a group health plan or health insurance cov-  
17 erage the following:

18 (1) STATUS OF PROVIDERS.—The State licen-  
19 sure status of the plan or issuer's participating  
20 health care professionals and participating health  
21 care facilities, and, if available, the education, train-  
22 ing, specialty qualifications or certifications of such  
23 professionals.

24 (2) COMPENSATION METHODS.—A summary  
25 description by category of the applicable methods

1 (such as capitation, fee-for-service, salary, bundled  
2 payments, per diem, or a combination thereof) used  
3 for compensating prospective or treating health care  
4 professionals (including primary care providers and  
5 specialists) and facilities in connection with the pro-  
6 vision of health care under the plan or coverage.

7 (3) PRESCRIPTION DRUGS.—Information about  
8 whether a specific prescription medication is in-  
9 cluded in the formulary of the plan or issuer, if the  
10 plan or issuer uses a defined formulary.

11 (4) UTILIZATION REVIEW ACTIVITIES.—A de-  
12 scription of procedures used and requirements (in-  
13 cluding circumstances, timeframes, and appeals  
14 rights) under any utilization review program under  
15 section 101 and section 503A of the Employee Re-  
16 tirement Income Security Act of 1974, including any  
17 drug formulary program under section 118.

18 (5) EXTERNAL APPEALS INFORMATION.—Ag-  
19 gregate information on the number and outcomes of  
20 external medical reviews, relative to the sample size  
21 (such as the number of covered lives) under the plan  
22 or under the coverage of the issuer.

23 (d) MANNER OF DISCLOSURE.—The information de-  
24 scribed in this section shall be disclosed in an accessible

1 medium and format that is calculated to be understood  
2 by a participant or enrollee.

3 (e) RULES OF CONSTRUCTION.—Nothing in this sec-  
4 tion shall be construed to prohibit a group health plan,  
5 or a health insurance issuer in connection with health in-  
6 surance coverage, from—

7 (1) distributing any other additional informa-  
8 tion determined by the plan or issuer to be impor-  
9 tant or necessary in assisting participants, bene-  
10 ficiaries, and enrollees in the selection of a health  
11 plan or health insurance coverage; and

12 (2) complying with the provisions of this section  
13 by providing information in brochures, through the  
14 Internet or other electronic media, or through other  
15 similar means, so long as—

16 (A) the disclosure of such information in  
17 such form is in accordance with requirements  
18 as the appropriate Secretary may impose; and

19 (B) in connection with any such disclosure  
20 of information through the Internet or other  
21 electronic media—

22 (i) the recipient has affirmatively con-  
23 sented to the disclosure of such informa-  
24 tion in such form;

1 (ii) the recipient is capable of access-  
2 ing the information so disclosed on the re-  
3 cipient's individual workstation or at the  
4 recipient's home;

5 (iii) the recipient retains an ongoing  
6 right to receive paper disclosure of such in-  
7 formation and receives, in advance of any  
8 attempt at disclosure of such information  
9 to him or her through the Internet or  
10 other electronic media, notice in printed  
11 form of such ongoing right and of the  
12 proper software required to view informa-  
13 tion so disclosed; and

14 (iv) the plan administrator appro-  
15 priately ensures that the intended recipient  
16 is receiving the information so disclosed  
17 and provides the information in printed  
18 form if the information is not received.

## 19 **Subtitle D—Protecting the Doctor-** 20 **Patient Relationship**

### 21 **SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN** 22 **MEDICAL COMMUNICATIONS.**

23 (a) GENERAL RULE.—The provisions of any contract  
24 or agreement, or the operation of any contract or agree-  
25 ment, between a group health plan or health insurance

1 issuer in relation to health insurance coverage (including  
2 any partnership, association, or other organization that  
3 enters into or administers such a contract or agreement)  
4 and a health care provider (or group of health care pro-  
5 viders) shall not prohibit or otherwise restrict a health  
6 care professional from advising such a participant, bene-  
7 ficiary, or enrollee who is a patient of the professional  
8 about the health status of the individual or medical care  
9 or treatment for the individual's condition or disease, re-  
10 gardless of whether benefits for such care or treatment  
11 are provided under the plan or coverage, if the professional  
12 is acting within the lawful scope of practice.

13 (b) NULLIFICATION.—Any contract provision or  
14 agreement that restricts or prohibits medical communica-  
15 tions in violation of subsection (a) shall be null and void.

16 **SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PRO-**  
17 **VIDERS BASED ON LICENSURE.**

18 (a) IN GENERAL.—A group health plan, and a health  
19 insurance issuer with respect to health insurance coverage,  
20 shall not discriminate with respect to participation or in-  
21 demnification as to any provider who is acting within the  
22 scope of the provider's license or certification under appli-  
23 cable State law, solely on the basis of such license or cer-  
24 tification.

1 (b) CONSTRUCTION.—Subsection (a) shall not be  
2 construed—

3 (1) as requiring the coverage under a group  
4 health plan or health insurance coverage of a par-  
5 ticular benefit or service or to prohibit a plan or  
6 issuer from including providers only to the extent  
7 necessary to meet the needs of the plan’s or issuer’s  
8 participants, beneficiaries, or enrollees or from es-  
9 tablishing any measure designed to maintain quality  
10 and control costs consistent with the responsibilities  
11 of the plan or issuer;

12 (2) to override any State licensure or scope-of-  
13 practice law; or

14 (3) as requiring a plan or issuer that offers net-  
15 work coverage to include for participation every will-  
16 ing provider who meets the terms and conditions of  
17 the plan or issuer.

18 **SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE**  
19 **ARRANGEMENTS.**

20 (a) IN GENERAL.—A group health plan and a health  
21 insurance issuer offering health insurance coverage may  
22 not operate any physician incentive plan (as defined in  
23 subparagraph (B) of section 1852(j)(4) of the Social Secu-  
24 rity Act) unless the requirements described in clauses (i),

1 (ii)(I), and (iii) of subparagraph (A) of such section are  
2 met with respect to such a plan.

3 (b) APPLICATION.—For purposes of carrying out  
4 paragraph (1), any reference in section 1852(j)(4) of the  
5 Social Security Act to the Secretary, a Medicare+Choice  
6 organization, or an individual enrolled with the organiza-  
7 tion shall be treated as a reference to the applicable au-  
8 thority, a group health plan or health insurance issuer,  
9 respectively, and a participant, beneficiary, or enrollee  
10 with the plan or organization, respectively.

11 (c) CONSTRUCTION.—Nothing in this section shall be  
12 construed as prohibiting all capitation and similar ar-  
13 rangements or all provider discount arrangements.

14 **SEC. 134. PAYMENT OF CLAIMS.**

15 A group health plan, and a health insurance issuer  
16 offering health insurance coverage, shall provide for  
17 prompt payment of claims submitted for health care serv-  
18 ices or supplies furnished to a participant, beneficiary, or  
19 enrollee with respect to benefits covered by the plan or  
20 issuer, in a manner that is no less protective than the pro-  
21 visions of section 1842(c)(2) of the Social Security Act  
22 (42 U.S.C. 1395u(c)(2)).

23 **SEC. 135. PROTECTION FOR PATIENT ADVOCACY.**

24 (a) PROTECTION FOR USE OF UTILIZATION REVIEW  
25 AND GRIEVANCE PROCESS.—A group health plan, and a



1 health insurance issuer with respect to the provision of  
2 health insurance coverage, may not retaliate against a par-  
3 ticipant, beneficiary, enrollee, or health care provider  
4 based on the participant's, beneficiary's, enrollee's or pro-  
5 vider's use of, or participation in, a utilization review proc-  
6 ess or a grievance process of the plan or issuer (including  
7 an internal or external review or appeal process) under  
8 this title or under sections 503A, 503B, and 503C of the  
9 Employee Retirement Income Security Act of 1974.

10 (b) PROTECTION FOR QUALITY ADVOCACY BY  
11 HEALTH CARE PROFESSIONALS.—

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

16 (A) discloses information relating to the  
17 care, services, or conditions affecting one or  
18 more participants, beneficiaries, or enrollees of  
19 the plan or issuer to an appropriate public reg-  
20 ulatory agency, an appropriate private accredi-  
21 tation body, or appropriate management per-  
22 sonnel of the plan or issuer; or

23 (B) initiates, cooperates, or otherwise par-  
24 ticipates in an investigation or proceeding by

1           such an agency with respect to such care, serv-  
2           ices, or conditions.

3           If an institutional health care provider is a partici-  
4           pating provider with such a plan or issuer or other-  
5           wise receives payments for benefits provided by such  
6           a plan or issuer, the provisions of the previous sen-  
7           tence shall apply to the provider in relation to care,  
8           services, or conditions affecting one or more patients  
9           within an institutional health care provider in the  
10          same manner as they apply to the plan or issuer in  
11          relation to care, services, or conditions provided to  
12          one or more participants, beneficiaries, or enrollees;  
13          and for purposes of applying this sentence, any ref-  
14          erence to a plan or issuer is deemed a reference to  
15          the institutional health care provider.

16           (2) GOOD FAITH ACTION.—For purposes of  
17          paragraph (1), a protected health care professional  
18          is considered to be acting in good faith with respect  
19          to disclosure of information or participation if, with  
20          respect to the information disclosed as part of the  
21          action—

22                   (A) the disclosure is made on the basis of  
23                  personal knowledge and is consistent with that  
24                  degree of learning and skill ordinarily possessed  
25                  by health care professionals with the same li-

1           censure or certification and the same experi-  
2           ence;

3                 (B) the professional reasonably believes the  
4           information to be true;

5                 (C) the information evidences either a vio-  
6           lation of a law, rule, or regulation, of an appli-  
7           cable accreditation standard, or of a generally  
8           recognized professional or clinical standard or  
9           that a patient is in imminent hazard of loss of  
10          life or serious injury; and

11                (D) subject to subparagraphs (B) and (C)  
12          of paragraph (3), the professional has followed  
13          reasonable internal procedures of the plan,  
14          issuer, or institutional health care provider es-  
15          tablished for the purpose of addressing quality  
16          concerns before making the disclosure.

17          (3) EXCEPTION AND SPECIAL RULE.—

18                (A) GENERAL EXCEPTION.—Paragraph (1)  
19          does not protect disclosures that would violate  
20          Federal or State law or diminish or impair the  
21          rights of any person to the continued protection  
22          of confidentiality of communications provided  
23          by such law.

24                (B) NOTICE OF INTERNAL PROCEDURES.—  
25          Subparagraph (D) of paragraph (2) shall not

1           apply unless the internal procedures involved  
2           are reasonably expected to be known to the  
3           health care professional involved. For purposes  
4           of this subparagraph, a health care professional  
5           is reasonably expected to know of internal pro-  
6           cedures if those procedures have been made  
7           available to the professional through distribu-  
8           tion or posting.

9           (C) INTERNAL PROCEDURE EXCEPTION.—

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

12               (i) the disclosure relates to an immi-  
13               nent hazard of loss of life or serious injury  
14               to a patient;

15               (ii) the disclosure is made to an ap-  
16               propriate private accreditation body pursu-  
17               ant to disclosure procedures established by  
18               the body; or

19               (iii) the disclosure is in response to an  
20               inquiry made in an investigation or pro-  
21               ceeding of an appropriate public regulatory  
22               agency and the information disclosed is  
23               limited to the scope of the investigation or  
24               proceeding.

1           (4) ADDITIONAL CONSIDERATIONS.—It shall  
2 not be a violation of paragraph (1) to take an ad-  
3 verse action against a protected health care profes-  
4 sional if the plan, issuer, or provider taking the ad-  
5 verse action involved demonstrates that it would  
6 have taken the same adverse action even in the ab-  
7 sence of the activities protected under such para-  
8 graph.

9           (5) NOTICE.—A group health plan, health in-  
10 surance issuer, and institutional health care provider  
11 shall post a notice, to be provided or approved by  
12 the Secretary of Labor, setting forth excerpts from,  
13 or summaries of, the pertinent provisions of this  
14 subsection and information pertaining to enforce-  
15 ment of such provisions.

16           (6) CONSTRUCTIONS.—

17           (A) DETERMINATIONS OF COVERAGE.—  
18 Nothing in this subsection shall be construed to  
19 prohibit a plan or issuer from making a deter-  
20 mination not to pay for a particular medical  
21 treatment or service or the services of a type of  
22 health care professional.

23           (B) ENFORCEMENT OF PEER REVIEW PRO-  
24 TOCOLS AND INTERNAL PROCEDURES.—Noth-  
25 ing in this subsection shall be construed to pro-

hibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

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

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the

1 provider respecting the provision of health care  
2 services.

## 3 **Subtitle E—Definitions**

### 4 **SEC. 151. DEFINITIONS.**

5 (a) INCORPORATION OF GENERAL DEFINITIONS.—  
6 Except as otherwise provided, the provisions of section  
7 2791 of the Public Health Service Act shall apply for pur-  
8 poses of this title in the same manner as they apply for  
9 purposes of title XXVII of such Act.

10 (b) SECRETARY.—Except as otherwise provided, the  
11 term “Secretary” means the Secretary of Health and  
12 Human Services, in consultation with the Secretary of  
13 Labor and the term “appropriate Secretary” means the  
14 Secretary of Health and Human Services in relation to  
15 carrying out this title under sections 2706 and 2751 of  
16 the Public Health Service Act and the Secretary of Labor  
17 in relation to carrying out this title under section 714 of  
18 the Employee Retirement Income Security Act of 1974.

19 (c) ADDITIONAL DEFINITIONS.—For purposes of this  
20 title:

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

23 (A) in the case of a group health plan, the  
24 Secretary of Health and Human Services and  
25 the Secretary of Labor; and

1 (B) in the case of a health insurance issuer  
2 with respect to a specific provision of this title,  
3 the applicable State authority (as defined in  
4 section 2791(d) of the Public Health Service  
5 Act), or the Secretary of Health and Human  
6 Services, if such Secretary is enforcing such  
7 provision under section 2722(a)(2) or  
8 2761(a)(2) of the Public Health Service Act.

9 (2) ENROLLEE.—The term “enrollee” means,  
10 with respect to health insurance coverage offered by  
11 a health insurance issuer, an individual enrolled with  
12 the issuer to receive such coverage.

13 (3) GROUP HEALTH PLAN.—The term “group  
14 health plan” has the meaning given such term in  
15 section 733(a) of the Employee Retirement Income  
16 Security Act of 1974, except that such term includes  
17 a employee welfare benefit plan treated as a group  
18 health plan under section 732(d) of such Act or de-  
19 fined as such a plan under section 607(1) of such  
20 Act.

21 (4) HEALTH CARE PROFESSIONAL.—The term  
22 “health care professional” means an individual who  
23 is licensed, accredited, or certified under State law  
24 to provide specified health care services and who is



1 operating within the scope of such licensure, accredi-  
2 tation, or certification.

3 (5) HEALTH CARE PROVIDER.—The term  
4 “health care provider” includes a physician or other  
5 health care professional, as well as an institutional  
6 or other facility or agency that provides health care  
7 services and that is licensed, accredited, or certified  
8 to provide health care items and services under ap-  
9 plicable State law.

10 (6) NETWORK.—The term “network” means,  
11 with respect to a group health plan or health insur-  
12 ance issuer offering health insurance coverage, the  
13 participating health care professionals and providers  
14 through whom the plan or issuer provides health  
15 care items and services to participants, beneficiaries,  
16 or enrollees.

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

24 (8) PARTICIPATING.—The term “participating”  
25 means, with respect to a health care provider that

1 provides health care items and services to a partici-  
2 pant, beneficiary, or enrollee under group health  
3 plan or health insurance coverage offered by a  
4 health insurance issuer, a health care provider that  
5 furnishes such items and services under a contract  
6 or other arrangement with the plan or issuer.

7 (9) PRIOR AUTHORIZATION.—The term “prior  
8 authorization” means the process of obtaining prior  
9 approval from a health insurance issuer or group  
10 health plan for the provision or coverage of medical  
11 services.

12 (10) TERMS AND CONDITIONS.—The term  
13 “terms and conditions” includes, with respect to a  
14 group health plan or health insurance coverage, re-  
15 quirements imposed under this title and sections  
16 503A, 503B, and 503C of the Employee Retirement  
17 Income Security Act of 1974 with respect to the  
18 plan or coverage.

19 (11) REFERENCES TO PROVISIONS GOVERNING  
20 CONSIDERATION OF CLAIMS AND APPEALS OF  
21 CLAIMS DECISIONS.—Any reference in this title to  
22 section 503A, 503B, or 503C of the Employee Re-  
23 tirement Income Security Act of 1974 shall be  
24 deemed, for purposes of the Public Health Service  
25 Act and the Internal Revenue Code of 1986, a ref-

1       erence to the provisions of such section as made ap-  
2       plicable under section 2707 or 2753 of the Public  
3       Health Service Act or section 9813 of the Internal  
4       Revenue Code of 1986, as applicable.

5   **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**  
6                   **TION.**

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

9           (1) IN GENERAL.—Subject to paragraph (2),  
10       this title (and the amendments made thereby) shall  
11       not be construed to supersede any provision of State  
12       law which establishes, implements, or continues in  
13       effect any standard or requirement solely relating to  
14       health insurance issuers (in connection with group  
15       health insurance coverage or otherwise) except to the  
16       extent that such standard or requirement prevents  
17       the application of a requirement of this title (or such  
18       amendments).

19           (2) CONTINUED PREEMPTION WITH RESPECT  
20       TO GROUP HEALTH PLANS.—Nothing in this title (or  
21       the amendments made thereby) shall be construed to  
22       affect or modify the provisions of section 514 of the  
23       Employee Retirement Income Security Act of 1974  
24       with respect to group health plans.

1           (3) CONSTRUCTION.—In applying this section,  
2           a State law that provides for equal access to, and  
3           availability of, all categories of licensed health care  
4           providers and services shall not be treated as pre-  
5           venting the application of any requirement of this  
6           title (or the amendments made thereby).

7           (b) APPLICATION OF SUBSTANTIALLY COMPLIANT  
8   STATE LAWS.—

9           (1) IN GENERAL.—In the case of a State law  
10          that imposes, with respect to health insurance cov-  
11          erage offered by a health insurance issuer and with  
12          respect to a group health plan that is a non-Federal  
13          governmental plan, a requirement that substantially  
14          complies (within the meaning of subsection (c)) with  
15          a patient protection requirement (as defined in para-  
16          graph (3)) and does not prevent the application of  
17          other requirements under this Act or the amend-  
18          ments made thereby (except in the case of other sub-  
19          stantially compliant requirements), in applying the  
20          requirements of this title under section 2707 and  
21          2753 (as applicable) of the Public Health Service  
22          Act (as added by title II), subject to subsection  
23          (a)(2)—

24                       (A) the State law shall not be treated as  
25                       being superseded under subsection (a); and

1 (B) the State law shall apply instead of the  
2 patient protection requirement otherwise appli-  
3 cable with respect to health insurance coverage  
4 and non-Federal governmental plans.

5 (2) LIMITATION.—In the case of a group health  
6 plan covered under title I of the Employee Retire-  
7 ment Income Security Act of 1974, paragraph (1)  
8 shall be construed to apply only with respect to the  
9 health insurance coverage (if any) offered in connec-  
10 tion with the plan and only with respect to patient  
11 protection requirements under section 101 and sub-  
12 titles B, C, and D and this subtitle.

13 (3) DEFINITIONS.—In this section:

14 (A) PATIENT PROTECTION REQUIRE-  
15 MENT.—The term “patient protection require-  
16 ment” means a requirement under this title (or  
17 the amendments made thereby), and includes  
18 (as a single requirement) a group or related set  
19 of requirements under a section or similar unit  
20 under this title (or such amendments).

21 (B) SUBSTANTIALLY COMPLIANT.—The  
22 terms “substantially compliant”, substantially  
23 complies”, or “substantial compliance” with re-  
24 spect to a State law, mean that the State law  
25 has the same or similar features as the patient

1 protection requirements and has a similar ef-  
2 fect.

3 (c) DETERMINATIONS OF SUBSTANTIAL COMPLI-  
4 ANCE.—

5 (1) CERTIFICATION BY STATES.—A State may  
6 submit to the Secretary a certification that a State  
7 law provides for patient protections that are at least  
8 substantially compliant with one or more patient  
9 protection requirements. Such certification shall be  
10 accompanied by such information as may be re-  
11 quired to permit the Secretary to make the deter-  
12 mination described in paragraph (2)(A).

13 (2) REVIEW.—

14 (A) IN GENERAL.—The Secretary shall  
15 promptly review a certification submitted under  
16 paragraph (1) with respect to a State law to de-  
17 termine if the State law substantially complies  
18 with the patient protection requirement (or re-  
19 quirements) to which the law relates.

20 (B) APPROVAL DEADLINES.—

21 (i) INITIAL REVIEW.—Such a certifi-  
22 cation is considered approved unless the  
23 Secretary notifies the State in writing,  
24 within 90 days after the date of receipt of  
25 the certification, that the certification is

disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—

With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply

1 with the patient protection requirement (or  
2 requirements) to which the law relates.

3 (B) STATE CHALLENGE.—A State that has  
4 a certification disapproved by the Secretary  
5 under subparagraph (A) may challenge such  
6 disapproval in the appropriate United States  
7 district court.

8 (C) DEFERENCE TO STATES.—With re-  
9 spect to a certification submitted under para-  
10 graph (1), the Secretary shall give deference to  
11 the State’s interpretation of the State law in-  
12 volved with respect to the patient protection in-  
13 volved.

14 (D) PUBLIC NOTIFICATION.—The Sec-  
15 retary shall—

16 (i) provide a State with a notice of the  
17 determination to approve or disapprove a  
18 certification under this paragraph;

19 (ii) promptly publish in the Federal  
20 Register a notice that a State has sub-  
21 mitted a certification under paragraph (1);

22 (iii) promptly publish in the Federal  
23 Register the notice described in clause (i)  
24 with respect to the State; and



1 (iv) annually publish the status of all  
2 States with respect to certifications.

3 (4) CONSTRUCTION.—Nothing in this sub-  
4 section shall be construed as preventing the certifi-  
5 cation (and approval of certification) of a State law  
6 under this subsection solely because it provides for  
7 greater protections for patients than those protec-  
8 tions otherwise required to establish substantial  
9 compliance.

10 (5) PETITIONS.—

11 (A) PETITION PROCESS.—Effective on the  
12 date on which the provisions of this Act become  
13 effective, as provided for in section 601, a  
14 group health plan, health insurance issuer, par-  
15 ticipant, beneficiary, or enrollee may submit a  
16 petition to the Secretary for an advisory opinion  
17 as to whether or not a standard or requirement  
18 under a State law applicable to the plan, issuer,  
19 participant, beneficiary, or enrollee that is not  
20 the subject of a certification under this sub-  
21 section, is superseded under subsection (a)(1)  
22 because such standard or requirement prevents  
23 the application of a requirement of this title (or  
24 the amendments made thereby).

1 (B) OPINION.—The Secretary shall issue  
2 an advisory opinion with respect to a petition  
3 submitted under subparagraph (A) within the  
4 60-day period beginning on the date on which  
5 such petition is submitted.

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

7 (1) STATE LAW.—The term “State law” in-  
8 cludes all laws, decisions, rules, regulations, or other  
9 State action having the effect of law, of any State.  
10 A law of the United States applicable only to the  
11 District of Columbia shall be treated as a State law  
12 rather than a law of the United States.

13 (2) STATE.—The term “State” includes a  
14 State, the District of Columbia, Puerto Rico, the  
15 Virgin Islands, Guam, American Samoa, the North-  
16 ern Mariana Islands, any political subdivisions of  
17 such, or any agency or instrumentality of such.

18 **SEC. 153. EXCLUSIONS.**

19 (a) NO BENEFIT REQUIREMENTS.—Nothing in this  
20 title or the amendments made thereby shall be construed  
21 to require a group health plan or a health insurance issuer  
22 offering health insurance coverage to include specific items  
23 and services under the terms of such a plan or coverage,  
24 other than those provided under the terms and conditions  
25 of such plan or coverage.

1 (b) EXCLUSION FROM ACCESS TO CARE MANAGED  
2 CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

3 (1) IN GENERAL.—The provisions of sections  
4 111 through 117 shall not apply to a group health  
5 plan or health insurance coverage if the only cov-  
6 erage offered under the plan or coverage is fee-for-  
7 service coverage (as defined in paragraph (2)).

8 (2) FEE-FOR-SERVICE COVERAGE DEFINED.—  
9 For purposes of this subsection, the term “fee-for-  
10 service coverage” means coverage under a group  
11 health plan or health insurance coverage that—

12 (A) reimburses hospitals, health profes-  
13 sionals, and other providers on a fee-for-service  
14 basis without placing the provider at financial  
15 risk;

16 (B) does not vary reimbursement for such  
17 a provider based on an agreement to contract  
18 terms and conditions or the utilization of health  
19 care items or services relating to such provider;

20 (C) allows access to any provider that is  
21 lawfully authorized to provide the covered serv-  
22 ices and that agrees to accept the terms and  
23 conditions of payment established under the  
24 plan or by the issuer; and

1 (D) for which the plan or issuer does not  
2 require prior authorization before providing for  
3 any health care services.

4 **SEC. 154. TREATMENT OF EXCEPTED BENEFITS.**

5 (a) IN GENERAL.—The requirements of this title and  
6 the amendments made thereby shall not apply to excepted  
7 benefits (as defined in section 733(c) of the Employee Re-  
8 tirement Income Security Act of 1974), other than bene-  
9 fits described in section 733(c)(2)(A) of such Act, in the  
10 same manner as the provisions of part 7 of subtitle B of  
11 title I of such Act do not apply to such benefits under  
12 subsections (b) and (c) of section 732 of such Act.

13 (b) COVERAGE OF CERTAIN LIMITED SCOPE  
14 PLANS.—Only for purposes of applying the requirements  
15 of this title and sections 503A, 503B, and 503C of the  
16 Employee Retirement Income Security Act of 1974 under  
17 sections 2707 and 2753 of the Public Health Service Act,  
18 sections 503(b) and 714 of the Employee Retirement In-  
19 come Security Act of 1974, and section 9813 of the Inter-  
20 nal Revenue Code of 1986, the following sections shall be  
21 deemed not to apply:

22 (1) Section 2791(c)(2)(A) of the Public Health  
23 Service Act.

24 (2) Section 733(c)(2)(A) of the Employee Re-  
25 tirement Income Security Act of 1974.

1           (3) Section 9832(c)(2)(A) of the Internal Rev-  
2           enue Code of 1986.

3   **SEC. 155. REGULATIONS.**

4           The Secretaries of Health and Human Services,  
5   Labor, and the Treasury shall issue such regulations as  
6   may be necessary or appropriate to carry out this title and  
7   the amendments made thereby. Such regulations shall be  
8   issued consistent with section 104 of Health Insurance  
9   Portability and Accountability Act of 1996. Such Secre-  
10   taries may promulgate any interim final rules as the Sec-  
11   retaries determine are appropriate to carry out this title  
12   and the amendments made thereby.

13   **SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOC-**  
14                   **UMENTS.**

15           The requirements of this title and the amendments  
16   made thereby with respect to a group health plan or health  
17   insurance coverage are, subject to section 154, deemed to  
18   be incorporated into, and made a part of, such plan or  
19   the policy, certificate, or contract providing such coverage  
20   and are enforceable under law as if directly included in  
21   the documentation of such plan or such policy, certificate,  
22   or contract.

23   **SEC. 157. PRESERVATION OF PROTECTIONS.**

24           (a) IN GENERAL.—The rights under this Act (includ-  
25   ing the right to maintain a civil action and any other

1 rights under the amendments made by this Act) may not  
 2 be waived, deferred, or lost pursuant to any agreement  
 3 not authorized under this Act (or such amendments).

4 (b) EXCEPTION.—Subsection (a) shall not apply to  
 5 an agreement providing for arbitration or participation in  
 6 any other nonjudicial procedure to resolve a dispute if the  
 7 agreement is entered into knowingly and voluntarily by the  
 8 parties involved after the dispute has arisen or is pursuant  
 9 to the terms of a collective bargaining agreement. Nothing  
 10 in this subsection shall be construed to permit the waiver  
 11 of the requirements of sections 503B and 503C of the Em-  
 12 ployee Retirement Income Security Act of 1974 (relating  
 13 to internal and external review).

14 **TITLE II—APPLICATION OF**  
 15 **QUALITY CARE STANDARDS**  
 16 **TO GROUP HEALTH PLANS**  
 17 **AND HEALTH INSURANCE**  
 18 **COVERAGE UNDER THE PUB-**  
 19 **LIC HEALTH SERVICE ACT**

20 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**  
 21 **GROUP HEALTH INSURANCE COVERAGE.**

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

1 **“SEC. 2707. PATIENT PROTECTION STANDARDS.**

2 “Each group health plan shall comply with the pa-  
3 tient protection requirements under title I of the Bipar-  
4 tisan Patient Protection Act and sections 503A through  
5 503C of the Employee Retirement Income Security Act  
6 of 1974, and each health insurance issuer shall comply  
7 with such patient protection requirements with respect to  
8 group health insurance coverage it offers, and such re-  
9 quirements shall be deemed to be incorporated into this  
10 subsection.”.

11 (b) CONFORMING AMENDMENT.—Section  
12 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))  
13 is amended by inserting “(other than section 2707)” after  
14 “requirements of such subparts”.

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

17 Part B of title XXVII of the Public Health Service  
18 Act is amended by inserting after section 2752 the fol-  
19 lowing new section:

20 **“SEC. 2753. PATIENT PROTECTION STANDARDS.**

21 “Each health insurance issuer shall comply with the  
22 patient protection requirements under title I of the Bipar-  
23 tisan Patient Protection Act and sections 503A through  
24 503C of the Employee Retirement Income Security Act  
25 of 1974 (with respect to enrollees under individual health  
26 insurance coverage in the same manner as they apply to

1 participants and beneficiaries under group health insur-  
 2 ance coverage) with respect to individual health insurance  
 3 coverage it offers, and such requirements shall be deemed  
 4 to be incorporated into this subsection.”.

5 **SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE**  
 6 **AUTHORITIES.**

7 Part C of title XXVII of the Public Health Service  
 8 Act (42 U.S.C. 300gg–91 et seq.) is amended by adding  
 9 at the end the following:

10 **“SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE**  
 11 **AUTHORITIES.**

12 “(a) AGREEMENT WITH STATES.—A State may enter  
 13 into an agreement with the Secretary for the delegation  
 14 to the State of some or all of the Secretary’s authority  
 15 under this title to enforce the requirements applicable  
 16 under sections 2707 and 2753 with respect to health in-  
 17 surance coverage offered by a health insurance issuer and  
 18 with respect to a group health plan that is a non-Federal  
 19 governmental plan.

20 “(b) DELEGATIONS.—Any department, agency, or in-  
 21 strumentality of a State to which authority is delegated  
 22 pursuant to an agreement entered into under this section  
 23 may, if authorized under State law and to the extent con-  
 24 sistent with such agreement, exercise the powers of the  
 25 Secretary under this title which relate to such authority.”.



1 **TITLE III—APPLICATION OF PA-**  
2 **TIENT PROTECTION STAND-**  
3 **ARDS TO FEDERAL HEALTH**  
4 **INSURANCE PROGRAMS**

5 **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**  
6 **ARDS TO FEDERAL HEALTH INSURANCE PRO-**  
7 **GRAMS.**

8 (a) SENSE OF CONGRESS.—It is the sense of Con-  
9 gress that enrollees in Federal health insurance programs  
10 should have the same rights and privileges as those af-  
11 forced under title I, under the amendments made by such  
12 title, and under the amendments made by subtitle A of  
13 title IV to participants and beneficiaries under group  
14 health plans.

15 (b) CONFORMING FEDERAL HEALTH INSURANCE  
16 PROGRAMS.—It is the sense of Congress that the Presi-  
17 dent should require, by executive order, the Federal offi-  
18 cial with authority over each Federal health insurance pro-  
19 gram, to the extent feasible, to take such steps as are nec-  
20 essary to implement the rights and privileges described in  
21 subsection (a) with respect to such program.

22 (c) GAO REPORT ON ADDITIONAL STEPS RE-  
23 QUIRED.—Not later than 1 year after the date of the en-  
24 actment of this Act, the Comptroller General of the United  
25 States shall submit to Congress a report on statutory

1 changes that are required to implement such rights and  
 2 privileges in a manner that is consistent with the missions  
 3 of the Federal health insurance programs and that avoids  
 4 unnecessary duplication or disruption of such programs.

5 (d) FEDERAL HEALTH INSURANCE PROGRAM.—In  
 6 this section, the term “Federal health insurance program”  
 7 means a Federal program that provides creditable cov-  
 8 erage (as defined in section 2701(c)(1) of the Public  
 9 Health Service Act) and includes a health program of the  
 10 Department of Veterans Affairs.

11 **TITLE IV—AMENDMENTS TO THE**  
 12 **EMPLOYEE RETIREMENT IN-**  
 13 **COME SECURITY ACT OF 1974**  
 14 **Subtitle A—General Provisions**

15 **SEC. 401. APPLICATION OF PATIENT PROTECTION STAND-**  
 16 **ARDS TO GROUP HEALTH PLANS AND GROUP**  
 17 **HEALTH INSURANCE COVERAGE UNDER THE**  
 18 **EMPLOYEE RETIREMENT INCOME SECURITY**  
 19 **ACT OF 1974.**

20 Subpart B of part 7 of subtitle B of title I of the  
 21 Employee Retirement Income Security Act of 1974 is  
 22 amended by adding at the end the following new section:

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

24 “(a) IN GENERAL.—Subject to subsection (b), a  
 25 group health plan (and a health insurance issuer offering

1 group health insurance coverage in connection with such  
2 a plan) shall comply with the requirements of section 101  
3 and subtitles B, C, D, and E of title I of the Bipartisan  
4 Patient Protection Act (as in effect as of the date of the  
5 enactment of such Act), and such requirements shall be  
6 deemed to be incorporated into this subsection.

7 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-  
8 MENTS.—

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

21 “(A) Section 111 (relating to consumer  
22 choice option).

23 “(B) Section 112 (relating to choice of  
24 health care professional).

1           “(C) Section 113 (relating to access to  
2 emergency care).

3           “(D) Section 114 (relating to timely access  
4 to specialists).

5           “(E) Section 115 (relating to patient ac-  
6 cess to obstetrical and gynecological care).

7           “(F) Section 116 (relating to access to pe-  
8 diatric care).

9           “(G) Section 117 (relating to continuity of  
10 care), but only insofar as a replacement issuer  
11 assumes the obligation for continuity of care.

12           “(H) Section 118 (relating to access to  
13 needed prescription drugs).

14           “(I) Section 119 (relating to coverage for  
15 individuals participating in approved clinical  
16 trials).

17           “(J) Section 120 (relating to required cov-  
18 erage for minimum hospital stay for  
19 mastectomies and lymph node dissections for  
20 the treatment of breast cancer and coverage for  
21 secondary consultations).

22           “(K) Section 134 (relating to payment of  
23 claims).

24           “(2) INFORMATION.—With respect to informa-  
25 tion required to be provided or made available under

1 section 121 of the Bipartisan Patient Protection  
2 Act, in the case of a group health plan that provides  
3 benefits in the form of health insurance coverage  
4 through a health insurance issuer, the Secretary  
5 shall determine the circumstances under which the  
6 plan is not required to provide or make available the  
7 information (and is not liable for the issuer's failure  
8 to provide or make available the information), if the  
9 issuer is obligated to provide and make available (or  
10 provides and makes available) such information.

11 “(3) APPLICATION TO PROHIBITIONS.—Pursu-  
12 ant to rules of the Secretary, if a health insurance  
13 issuer offers health insurance coverage in connection  
14 with a group health plan and takes an action in vio-  
15 lation of any of the following sections of the Bipar-  
16 tisan Patient Protection Act, the group health plan  
17 shall not be liable for such violation unless the plan  
18 caused such violation:

19 “(A) Section 131 (relating to prohibition of  
20 interference with certain medical communica-  
21 tions).

22 “(B) Section 132 (relating to prohibition  
23 of discrimination against providers based on li-  
24 censure).

1           “(C) Section 133 (relating to prohibition  
2           against improper incentive arrangements).

3           “(D) Section 135 (relating to protection  
4           for patient advocacy).

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

9           “(5) TREATMENT OF SUBSTANTIALLY COMPLI-  
10          ANT STATE LAWS.—For purposes of applying this  
11          subsection in connection with health insurance cov-  
12          erage, any reference in this subsection to a require-  
13          ment in a section or other provision in the Bipar-  
14          tisan Patient Protection Act with respect to a health  
15          insurance issuer is deemed to include a reference to  
16          a requirement under a State law that substantially  
17          complies (as determined under section 152(c) of  
18          such Act) with the requirement in such section or  
19          other provisions.

20          “(6) APPLICATION TO CERTAIN PROHIBITIONS  
21          AGAINST RETALIATION.—With respect to compliance  
22          with the requirements of section 135(b)(1) of the Bi-  
23          partisan Patient Protection Act, for purposes of this  
24          subtitle the term ‘group health plan’ is deemed to in-

1       clude a reference to an institutional health care pro-  
2       vider.

3       “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

4               “(1) COMPLAINTS.—Any protected health care  
5       professional who believes that the professional has  
6       been retaliated or discriminated against in violation  
7       of section 135(b)(1) of the Bipartisan Patient Pro-  
8       tection Act may file with the Secretary a complaint  
9       within 180 days of the date of the alleged retaliation  
10      or discrimination.

11             “(2) INVESTIGATION.—The Secretary shall in-  
12      vestigate such complaints and shall determine if a  
13      violation of such section has occurred and, if so,  
14      shall issue an order to ensure that the protected  
15      health care professional does not suffer any loss of  
16      position, pay, or benefits in relation to the plan,  
17      issuer, or provider involved, as a result of the viola-  
18      tion found by the Secretary.

19       “(d) CONFORMING REGULATIONS.—The Secretary  
20      shall issue regulations to coordinate the requirements on  
21      group health plans and health insurance issuers under this  
22      section with the requirements imposed under the other  
23      provisions of this title. In order to reduce duplication and  
24      clarify the rights of participants and beneficiaries with re-  
25      spect to information that is required to be provided, such

1 regulations shall coordinate the information disclosure re-  
2 quirements under section 121 of the Bipartisan Patient  
3 Protection Act with the reporting and disclosure require-  
4 ments imposed under part 1, so long as such coordination  
5 does not result in any reduction in the information that  
6 would otherwise be provided to participants and bene-  
7 ficiaries.”.

8 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE  
9 REQUIREMENT.—Section 503 of such Act (29 U.S.C.  
10 1133) is amended by inserting “(a)” after “SEC. 503.”  
11 and by adding at the end the following new subsection:  
12 “(b)(1)(A) Subject to subparagraphs (B) and (C), a  
13 group health plan (and a health insurance issuer offering  
14 group health insurance coverage in connection with such  
15 a plan) shall comply with the requirements of sections  
16 503A, 503B, and 503C, and such requirements shall be  
17 deemed to be incorporated into this subsection.

18 “(B) With respect to the internal appeals process re-  
19 quired to be established under section 503B, in the case  
20 of a group health plan that provides benefits in the form  
21 of health insurance coverage through a health insurance  
22 issuer, the Secretary shall determine the circumstances  
23 under which the plan is not required to provide for such  
24 process and system (and is not liable for the issuer’s fail-  
25 ure to provide for such process and system), if the issuer



1 is obligated to provide for (and provides for) such process  
2 and system.

3 “(C) Pursuant to rules of the Secretary, insofar as  
4 a group health plan enters into a contract with a qualified  
5 external review entity for the conduct of external appeal  
6 activities in accordance with section 503C, the plan shall  
7 be treated as meeting the requirement of such section and  
8 is not liable for the entity’s failure to meet any require-  
9 ments under such section.

10 “(2) In the case of a group health plan, compliance  
11 with the requirements of sections 503A, 503B, and 503C,  
12 and compliance with regulations promulgated by the Sec-  
13 retary, in connection with a denial of a claim under a  
14 group health plan shall be deemed compliance with sub-  
15 section (a) with respect to such claim denial.

16 “(3) Terms used in this subsection which are defined  
17 in section 733 shall have the meanings provided such  
18 terms in such section.”.

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

22 (2) The table of contents in section 1 of such Act  
23 is amended by inserting after the item relating to section  
24 713 the following new item:

“Sec. 714. Patient protection standards.”.

1       (3) Section 502(b)(3) of such Act (29 U.S.C.  
 2 1132(b)(3)) is amended by inserting “(other than section  
 3 135(b) of the Bipartisan Patient Protection Act, as  
 4 enforceable under section 714(c))” after “part 7”.

5 **SEC. 402. AVAILABILITY OF CIVIL REMEDIES.**

6       (a) IN GENERAL.—Section 502 of the Employee Re-  
 7 tirement Income Security Act of 1974 (29 U.S.C. 1132)  
 8 is amended by adding at the end the following:

9       “(n) CAUSE OF ACTION RELATING TO CLAIMS FOR  
 10 HEALTH BENEFITS.—

11               “(1) CAUSE OF ACTION.—

12                       “(A) IN GENERAL.—With respect to an ac-  
 13 tion commenced by a participant or beneficiary  
 14 (or the estate of the participant or beneficiary)  
 15 in connection with a claim for benefits under a  
 16 group health plan, if—

17                               “(i) a designated decisionmaker de-  
 18 scribed in paragraph (2) fails to exercise  
 19 ordinary care—

20                                       “(I) in making a determination  
 21 denying the claim for benefits under  
 22 section 503A (relating to an initial  
 23 claim for benefits),

24                                       “(II) in making a determination  
 25 denying the claim for benefits under

1 section 503B (relating to an internal  
2 appeal), or

3 “(III) in failing to authorize cov-  
4 erage in compliance with the written  
5 determination of an independent med-  
6 ical reviewer under section  
7 503C(d)(3)(F) that reverses a deter-  
8 mination denying the claim for bene-  
9 fits, and

10 “(ii) the delay in receiving, or failure  
11 to receive, benefits attributable to the fail-  
12 ure described in clause (i) is the proximate  
13 cause of personal injury to, or death of,  
14 the participant or beneficiary,  
15 such designated decisionmaker shall be liable to  
16 the participant or beneficiary (or the estate) for  
17 economic and noneconomic damages in connec-  
18 tion with such failure and such injury or death  
19 (subject to paragraph (4)).

20 “(B) REBUTTABLE PRESUMPTION.—In the  
21 case of a cause of action under subparagraph  
22 (A)(i)(I) or (A)(i)(II), if an independent med-  
23 ical reviewer under section 503C(d) or  
24 503C(e)(4)(B) upholds the determination deny-  
25 ing the claim for benefits involved, there shall

1 be a presumption (rebuttable by clear and con-  
2 vincing evidence) that the designated decision-  
3 maker exercised ordinary care in making such  
4 determination.

5 “(2) DESIGNATED DECISIONMAKER.—

6 “(A) APPOINTMENT.—

7 “(i) IN GENERAL.—The plan sponsor  
8 or named fiduciary of a group health plan  
9 shall, in accordance with this paragraph  
10 with respect to a participant or beneficiary,  
11 designate a person that meets the require-  
12 ments of subparagraph (B) to serve as a  
13 designated decisionmaker with respect to  
14 the cause of action described in paragraph  
15 (1), except that—

16 “(I) with respect to health insur-  
17 ance coverage offered in connection  
18 with a group health plan, the health  
19 insurance issuer shall be the des-  
20 ignated decisionmaker unless the plan  
21 sponsor and the issuer specifically  
22 agree in writing (on a form to be pre-  
23 scribed by the Secretary) to substitute  
24 another person as the designated deci-  
25 sionmaker; or

1 “(II) with respect to the designa-  
2 tion of a person other than a plan  
3 sponsor or health insurance issuer,  
4 such person shall satisfy the require-  
5 ments of subparagraph (D).

6 “(ii) PLAN DOCUMENTS.—The des-  
7 ignated decisionmaker shall be specifically  
8 designated as such in the written instru-  
9 ments of the plan (under section 402(a))  
10 and be identified as required under section  
11 121(b)(20) of the Bipartisan Patient Pro-  
12 tection Act.

13 “(B) REQUIREMENTS.—For purposes of  
14 this paragraph, a designated decisionmaker  
15 meets the requirements of this subparagraph  
16 with respect to any participant or beneficiary  
17 if—

18 “(i) such designation is in such form  
19 as may be specified in regulations pre-  
20 scribed by the Secretary,

21 “(ii) the designated decisionmaker—

22 “(I) meets the requirements of  
23 subparagraph (C),

24 “(II) assumes unconditionally all  
25 liability arising under this subsection

1 in connection with actions and failures  
2 to act described in subparagraph (A)  
3 (whether undertaken by the des-  
4 ignated decisionmaker or the em-  
5 ployer, plan, plan sponsor, or em-  
6 ployee or agent thereof) during the  
7 period in which the designation under  
8 this paragraph is in effect relating to  
9 such participant or beneficiary, and  
10 “(III) where subparagraph  
11 (C)(ii) applies, assumes uncondition-  
12 ally the exclusive authority under the  
13 group health plan to make determina-  
14 tions on claims for benefits (irrespec-  
15 tive of whether they constitute medi-  
16 cally reviewable determinations) under  
17 the plan with respect to such partici-  
18 pant or beneficiary, and  
19 “(iii) the designated decisionmaker  
20 and the participants and beneficiaries for  
21 whom the decisionmaker has assumed li-  
22 ability are identified in the written instru-  
23 ment required under section 402(a) and as  
24 required under section 121(b)(15) of the  
25 Bipartisan Patient Protection Act.

1 Any liability assumed by a designated decision-  
2 maker pursuant to this paragraph shall be in  
3 addition to any liability that it may otherwise  
4 have under applicable law.

5 “(C) QUALIFICATIONS FOR DESIGNATED  
6 DECISIONMAKERS.—

7 “(i) IN GENERAL.—Subject to clause  
8 (ii), an entity is qualified under this sub-  
9 paragraph to serve as a designated deci-  
10 sionmaker with respect to a group health  
11 plan if the entity has the ability to assume  
12 the liability described in subparagraph (A)  
13 with respect to participants and bene-  
14 ficiaries under such plan, including re-  
15 quirements relating to the financial obliga-  
16 tion for timely satisfying the assumed li-  
17 ability, and maintains with the plan spon-  
18 sor certification of such ability. Such cer-  
19 tification shall be provided to the plan  
20 sponsor or named fiduciary upon designa-  
21 tion under this paragraph and not less fre-  
22 quently than annually thereafter, or if such  
23 designation constitutes a multiyear ar-  
24 rangement, in conjunction with the renewal  
25 of the arrangement.

1                   “(ii) SPECIAL QUALIFICATION IN THE  
2                   CASE OF CERTAIN REVIEWABLE DECI-  
3                   SIONS.—In the case of a group health plan  
4                   that provides benefits consisting of medical  
5                   care to a participant or beneficiary only  
6                   through health insurance coverage offered  
7                   by a health insurance issuer, such issuer is  
8                   the only entity that may be qualified under  
9                   this subparagraph to serve as a designated  
10                  decisionmaker with respect to such partici-  
11                  pant or beneficiary, and shall serve as the  
12                  designated decisionmaker unless the em-  
13                  ployer or other plan sponsor acts affirma-  
14                  tively to prevent such service.

15               “(D) REQUIREMENTS RELATING TO FI-  
16               NANCIAL OBLIGATIONS.—For purposes of sub-  
17               paragraphs (A)(i)(II) and (C)(i), the require-  
18               ments relating to the financial obligation of an  
19               entity for liability shall include—

20                   “(i) coverage of such entity under an  
21                   insurance policy or other arrangement, se-  
22                   cured and maintained by such entity, to ef-  
23                   fectively insure such entity against losses  
24                   arising from professional liability claims,  
25                   including those arising from its service as



1 a designated decisionmaker under this sub-  
2 section; or

3 “(ii) evidence of minimum capital and  
4 surplus levels that are maintained by such  
5 entity to cover any losses as a result of li-  
6 ability arising from its service as a des-  
7 ignated decisionmaker under this sub-  
8 section.

9 The appropriate amounts of liability insurance  
10 and minimum capital and surplus levels for  
11 purposes of clauses (i) and (ii) shall be deter-  
12 mined by an actuary using sound actuarial  
13 principles and accounting practices pursuant to  
14 established guidelines of the American Academy  
15 of Actuaries and in accordance with such regu-  
16 lations as the Secretary may prescribe and shall  
17 be maintained throughout the term for which  
18 the designation is in effect. The provisions of  
19 this subparagraph shall not apply in the case of  
20 a designated decisionmaker that is a group  
21 health plan, plan sponsor, or health insurance  
22 issuer and that is regulated under Federal law  
23 or a State financial solvency law.

24 “(E) LIMITATION ON APPOINTMENT OF  
25 TREATING PHYSICIANS.—A treating physician

1 who directly delivered the care or treatment or  
2 provided services which is the subject of a cause  
3 of action by a participant or beneficiary under  
4 paragraph (1) may not be appointed (or deemed  
5 to be appointed) as a designated decisionmaker  
6 under this paragraph with respect to such par-  
7 ticipant or beneficiary.

8 “(F) FAILURE TO APPOINT.—With respect  
9 to any cause of action under paragraph (1) re-  
10 lating to a denial of a claim for benefits where  
11 a designated decisionmaker has not been ap-  
12 pointed in accordance with this paragraph, the  
13 plan sponsor or named fiduciary responsible for  
14 determinations under section 503 shall be  
15 deemed to be the designated decisionmaker.

16 “(G) EFFECT OF APPOINTMENT.—The ap-  
17 pointment of a designated decisionmaker in ac-  
18 cordance with this paragraph shall not affect  
19 the liability of the appointing plan sponsor or  
20 named fiduciary for the failure of the plan  
21 sponsor or named fiduciary to comply with any  
22 other requirement of this title.

23 “(H) TREATMENT OF CERTAIN TRUST  
24 FUNDS.—For purposes of this subsection, the  
25 terms ‘employer’ and ‘plan sponsor’, in connec-

tion with the assumption by a designated decisionmaker of the liability of employer or other plan sponsor pursuant to this paragraph, shall be construed to include a trust fund maintained pursuant to section 302 of the Labor Management Relations Act, 1947 (29 U.S.C. 186) or the Railway Labor Act (45 U.S.C. 151 et seq.).

“(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

“(A) IN GENERAL.—Paragraph (1) shall apply only if—

“(i) a final determination denying a claim for benefits under section 503B has been referred for independent medical review under section 503C(d) and a written determination by an independent medical reviewer has been issued with respect to such review, or

“(ii) the qualified external review entity has determined under section 503C(c)(3) that a referral to an independent medical reviewer is not required.

“(B) INJUNCTIVE RELIEF FOR IRREPARABLE HARM.—A participant or beneficiary may seek relief under subsection (a)(1)(B) prior

1 to the exhaustion of administrative remedies  
2 under section 503B or 503C (as required under  
3 subparagraph (A)) if it is demonstrated to the  
4 court, by a preponderance of the evidence, that  
5 the exhaustion of such remedies would cause ir-  
6 reparable harm to the health of the participant  
7 or beneficiary. Any determinations that already  
8 have been made under section 503A, 503B, or  
9 503C in such case, or that are made in such  
10 case while an action under this subparagraph is  
11 pending, shall be given due consideration by the  
12 court in any action under subsection (a)(1)(B)  
13 in such case. Notwithstanding the awarding of  
14 such relief under subsection (a)(1)(B) pursuant  
15 to this subparagraph, no relief shall be available  
16 under paragraph (1), with respect to a partici-  
17 pant or beneficiary, unless the requirements of  
18 subparagraph (A) are met.

19 “(C) RECEIPT OF BENEFITS DURING AP-  
20 PEALS PROCESS.—Receipt by the participant or  
21 beneficiary of the benefits involved in the claim  
22 for benefits during the pendency of any admin-  
23 istrative processes referred to in subparagraph  
24 (A) or of any action commenced under this  
25 subsection—

1 “(i) shall not preclude continuation of  
2 all such administrative processes to their  
3 conclusion if so moved by any party, and

4 “(ii) shall not preclude any liability  
5 under subsection (a)(1)(C) and this sub-  
6 section in connection with such claim.

7 The court in any action commenced under this  
8 subsection shall take into account any receipt of  
9 benefits during such administrative processes or  
10 such action in determining the amount of the  
11 damages awarded.

12 “(4) LIMITATIONS ON RECOVERY OF DAM-  
13 AGES.—

14 “(A) MAXIMUM AWARD OF NONECONOMIC  
15 DAMAGES.—The aggregate amount of liability  
16 for noneconomic loss in an action under para-  
17 graph (1) may not exceed \$1,500,000.

18 “(B) LIMITATION ON AWARD OF PUNITIVE  
19 DAMAGES.—In the case of any action com-  
20 menced pursuant to paragraph (1), the court  
21 may not award any punitive, exemplary, or  
22 similar damages against a defendant, except  
23 that the court may award punitive, exemplary,  
24 or similar damages (in addition to damages de-

scribed in subparagraph (A)), in an aggregate amount not to exceed \$1,500,000, if—

“(i) the denial of a claim for benefits involved in the case was reversed by a written determination by an independent medical reviewer under section 503C(d)(3)(F); and

“(ii) there has been a failure to authorize coverage in compliance with such written determination.

“(C) PERMITTING APPLICATION OF LOWER STATE DAMAGE LIMITS.—A State may limit damages for noneconomic loss or punitive, exemplary, or similar damages in an action under paragraph (1) to amounts less than the amounts permitted under this paragraph.

“(5) ADMISSIBILITY.—In an action described in subclause (I) or (II) of paragraph (1)(A) relating to a denial of a claim for benefits, any determination by an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) relating to such denial is admissible.

“(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section

1       503B(a)(4) by the group health plan, or health in-  
2       surance issuer that offers health insurance coverage  
3       in connection with a group health plan, shall not be  
4       used in determining liability.

5           “(7) LIMITATIONS ON ACTIONS.—Paragraph  
6       (1) shall not apply in connection with any action  
7       that is commenced more than 5 years after the date  
8       on which the failure described in such paragraph oc-  
9       curred or, if earlier, not later than 2 years after the  
10      first date the participant or beneficiary became  
11      aware of the personal injury or death referred to in  
12      such paragraph.

13          “(8) EXCLUSION OF DIRECTED RECORD-  
14      KEEPERS.—

15           “(A) IN GENERAL.—Paragraph (1) shall  
16      not apply with respect to a directed record  
17      keeper in connection with a group health plan.

18           “(B) DIRECTED RECORDKEEPER.—For  
19      purposes of this paragraph, the term ‘directed  
20      record keeper’ means, in connection with a  
21      group health plan, a person engaged in directed  
22      recordkeeping activities pursuant to the specific  
23      instructions of the plan, the employer, or an-  
24      other plan sponsor, including the distribution of  
25      enrollment information and distribution of dis-

1 closure materials under this Act or title I of the  
2 Bipartisan Patient Protection Act and whose  
3 duties do not include making determinations on  
4 claims for benefits.

5 “(C) LIMITATION.—Subparagraph (A)  
6 does not apply in connection with any directed  
7 recordkeeper to the extent that the directed rec-  
8 ordkeeper fails to follow the specific instruction  
9 of the plan or the employer or other plan spon-  
10 sor.

11 “(9) PROTECTION OF THE REGULATION OF  
12 QUALITY OF MEDICAL CARE UNDER STATE LAW.—  
13 Nothing in this subsection shall be construed to pre-  
14 clude any action under State law against a person  
15 or entity for liability or vicarious liability with re-  
16 spect to the delivery of medical care. A cause of ac-  
17 tion that is based on or otherwise relates to a group  
18 health plan’s determination on a claim for benefits  
19 shall not be deemed to be the delivery of medical  
20 care under any State law for purposes of this para-  
21 graph. Any such cause of action shall be maintained  
22 exclusively under this section. Nothing in this para-  
23 graph shall be construed to alter, amend, modify, in-  
24 validate, impair, or supersede section 514.



1           “(10) COORDINATION WITH FIDUCIARY RE-  
2           QUIREMENTS.—A fiduciary shall not be treated as  
3           failing to meet any requirement of part 4 solely by  
4           reason of any action taken by a fiduciary which con-  
5           sists of full compliance with the reversal under sec-  
6           tion 503C (relating to independent external appeals  
7           procedures for group health plans) of a denial of  
8           claim for benefits (within the meaning of section  
9           503C(i)(2)).

10           “(11) CONSTRUCTION.—Nothing in this sub-  
11           section shall be construed as authorizing a cause of  
12           action under paragraph (1) for the failure of a  
13           group health plan or health insurance issuer to pro-  
14           vide an item or service that is specifically excluded  
15           under the plan or coverage.

16           “(12) LIMITATION ON CLASS ACTION LITIGA-  
17           TION.—A claim or cause of action under this sub-  
18           section may not be maintained as a class action, as  
19           a derivative action, or as an action on behalf of any  
20           group of 2 or more claimants.

21           “(13) PURCHASE OF INSURANCE TO COVER LI-  
22           ABILITY.—Nothing in section 410 shall be construed  
23           to preclude the purchase by a group health plan of  
24           insurance to cover any liability or losses arising

1 under a cause of action under subsection (a)(1)(C)  
2 and this subsection.

3 “(14) RETROSPECTIVE CLAIMS FOR BENE-  
4 FITS.—A cause of action shall not arise under para-  
5 graph (1) where the claim for benefits relates to an  
6 item or service that has already been provided to the  
7 participant or beneficiary under the plan or coverage  
8 and the claim relates solely to the subsequent denial  
9 of payment for the provision of such item or service.

10 “(15) EXEMPTION FROM PERSONAL LIABILITY  
11 FOR INDIVIDUAL MEMBERS OF BOARDS OF DIREC-  
12 TORS, JOINT BOARDS OF TRUSTEES, ETC.—Any indi-  
13 vidual who is—

14 “(A) a member of a board of directors of  
15 an employer or plan sponsor; or

16 “(B) a member of an association, com-  
17 mittee, employee organization, joint board of  
18 trustees, or other similar group of representa-  
19 tives of the entities that are the plan sponsor  
20 of plan maintained by two or more employers  
21 and one or more employee organizations;

22 shall not be personally liable under this subsection  
23 for conduct that is within the scope of employment  
24 or of plan-related duties of the individuals unless the

1 individual acts in a fraudulent manner for personal  
2 enrichment.

3 “(16) DEFINITIONS AND RELATED RULES.—

4 For purposes of this subsection:

5 “(A) CLAIM FOR BENEFITS.—The term  
6 ‘claim for benefits’ shall have the meaning given  
7 such term in section 503A(e).

8 “(B) GROUP HEALTH PLAN.—The term  
9 ‘group health plan’ shall have the meaning  
10 given such term in section 733(a).

11 “(C) HEALTH INSURANCE COVERAGE.—  
12 The term ‘health insurance coverage’ has the  
13 meaning given such term in section 733(b)(1).

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

17 “(E) ORDINARY CARE.—The term ‘ordi-  
18 nary care’ means, with respect to a determina-  
19 tion on a claim for benefits, that degree of care,  
20 skill, and diligence that a reasonable and pru-  
21 dent individual would exercise in making a fair  
22 determination on a claim for benefits of like  
23 kind to the claims involved.

24 “(F) PERSONAL INJURY.—The term ‘per-  
25 sonal injury’ means a physical injury and in-

cludes an injury arising out of the treatment  
(or failure to treat) a mental illness or disease.

“(G) TREATMENT OF EXCEPTED BENEFITS.—The provisions of this subsection (and subsection (a)(1)(C)) shall not apply to excepted benefits (as defined in section 733(c)), other than benefits described in section 733(c)(2)(A), in the same manner as the provisions of part 7 do not apply to such benefits under subsections (b) and (c) of section 732.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking “or” at the end of subparagraph (A);

(B) in subparagraph (B), by striking “plan;” and inserting “plan, or”; and

(C) by adding at the end the following new subparagraph:

“(C) for the relief provided for in subsection (n) of this section.”.

(b) AVAILABILITY OF ACTIONS IN STATE COURT.—

(1) JURISDICTION OF STATE COURTS.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)) is amended—

1 (A) in the first sentence, by striking “sub-  
2 section (a)(1)(B)” and inserting “paragraphs  
3 (1)(B), (1)(C), and (7) of subsection (a)”;

4 (B) in the second sentence, by striking  
5 “paragraphs (1)(B) and (7)” and inserting  
6 “paragraphs (1)(B), (1)(C), and (7)”;

7 (C) by adding at the end the following new  
8 sentence: “State courts of competent jurisdic-  
9 tion in the State in which the plaintiff resides  
10 and district courts of the United States shall  
11 have concurrent jurisdiction over actions under  
12 subsections (a)(1)(C) and (n).”.

13 (2) LIMITATION ON REMOVABILITY OF CERTAIN  
14 ACTIONS IN STATE COURT.—Section 1445 of title  
15 28, United States Code, is amended by adding at  
16 the end the following new subsection:

17 “(e)(1) A civil action brought in any State court  
18 under subsections (a)(1)(C) and (n) of section 502 of the  
19 Employee Retirement Income Security Act of 1974  
20 against any party (other than the employer, plan, plan  
21 sponsor, or other entity treated under section 502(n) of  
22 such Act as such) arising from a medically reviewable de-  
23 termination may not be removed to any district court of  
24 the United States.

1       “(2) For purposes of paragraph (1), the term ‘medi-  
 2 cally reviewable decision’ means a denial of a claim for  
 3 benefits under the plan which is described in section  
 4 503C(d)(2) of the Employee Retirement Income Security  
 5 Act of 1974.”.

6       (c) EFFECTIVE DATE.—The amendments made by  
 7 this section shall apply to acts and omissions, from which  
 8 a cause of action arises, occurring on or after the applica-  
 9 ble effective date under section 601.

10 **SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGA-**  
 11 **TION.**

12       (a) IN GENERAL.—Section 502 of the Employee Re-  
 13 tirement Income Security Act of 1974 (29 U.S.C. 1132),  
 14 as amended by section 402, is further amended by adding  
 15 at the end the following:

16       “(o) LIMITATION ON CLASS ACTION LITIGATION.—  
 17 Any claim or cause of action that is maintained under this  
 18 section (other than under subsection (n)) or under section  
 19 1962 or 1964(c) of title 18, United States Code, in con-  
 20 nection with a group health plan, or health insurance cov-  
 21 erage issued in connection with a group health plan, as  
 22 a class action, derivative action, or as an action on behalf  
 23 of any group of 2 or more claimants, may be maintained  
 24 only if the class, the derivative claimant, or the group of  
 25 claimants is limited to the participants or beneficiaries of

1 a group health plan established by only 1 plan sponsor.  
 2 No action maintained by such class, such derivative claim-  
 3 ant, or such group of claimants may be joined in the same  
 4 proceeding with any action maintained by another class,  
 5 derivative claimant, or group of claimants or consolidated  
 6 for any purpose with any other proceeding. In this para-  
 7 graph, the terms ‘group health plan’ and ‘health insurance  
 8 coverage’ have the meanings given such terms in section  
 9 733.”.

10 (b) EFFECTIVE DATE.—The amendment made by  
 11 subsection (a) shall apply with respect to actions com-  
 12 menced on or after August 2, 2001. Notwithstanding the  
 13 preceding sentence, with respect to class actions, the  
 14 amendment made by subsection (a) shall apply with re-  
 15 spect to civil actions which are pending on such date in  
 16 which a class action has not been certified as of such date.

17 **SEC. 404. LIMITATIONS ON ACTIONS.**

18 Section 502 of the Employee Retirement Income Se-  
 19 curity Act of 1974 (29 U.S.C. 1132) (as amended by sec-  
 20 tions 402 and 403) is amended further by adding at the  
 21 end the following new subsection:

22 “(p) LIMITATIONS ON ACTIONS RELATING TO GROUP  
 23 HEALTH PLANS.—

24 “(1) IN GENERAL.—Except as provided in para-  
 25 graph (2), no action may be brought under sub-

1 section (a)(1)(B), (a)(2), or (a)(3) by a participant  
2 or beneficiary seeking relief based on the application  
3 of any provision in section 101, subtitle B, or sub-  
4 title D of title I of the Bipartisan Patient Protection  
5 Act (as incorporated under section 714).

6 “(2) CERTAIN ACTIONS ALLOWABLE.—An ac-  
7 tion may be brought under subsection (a)(1)(B),  
8 (a)(2), or (a)(3) by a participant or beneficiary seek-  
9 ing relief based on the application of section 101,  
10 113, 114, 115, 116, 117, 118(a)(3), 119, or 120 of  
11 the Bipartisan Patient Protection Act (as incor-  
12 porated under section 714) to the individual cir-  
13 cumstances of that participant or beneficiary, except  
14 that—

15 “(A) such an action may not be brought or  
16 maintained as a class action; and

17 “(B) in such an action, relief may only  
18 provide for the provision of (or payment of)  
19 benefits, items, or services denied to the indi-  
20 vidual participant or beneficiary involved (and  
21 for attorney’s fees and the costs of the action,  
22 at the discretion of the court) and shall not pro-  
23 vide for any other relief to the participant or  
24 beneficiary or for any relief to any other person.



1           “(3) OTHER PROVISIONS UNAFFECTED.—Noth-  
 2           ing in this subsection shall be construed as affecting  
 3           subsections (a)(1)(C) and (n).

4           “(4) ENFORCEMENT BY SECRETARY UNAF-  
 5           FECTED.—Nothing in this subsection shall be con-  
 6           strued as affecting any action brought by the Sec-  
 7           retary.”.

8   **SEC. 405. COOPERATION BETWEEN FEDERAL AND STATE**  
 9           **AUTHORITIES.**

10          (a) IN GENERAL.—Subpart C of part 7 of subtitle  
 11          B of title I of the Employee Retirement Income Security  
 12          Act of 1974 (29 U.S.C. 1191 et seq.) is amended by add-  
 13          ing at the end the following new section:

14   **“SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE**  
 15           **AUTHORITIES.**

16          “(a) AGREEMENT WITH STATES.—A State may enter  
 17          into an agreement with the Secretary for the delegation  
 18          to the State of some or all of the Secretary’s authority  
 19          under this title to enforce the requirements applicable  
 20          under sections 503A, 503B, 503C, and 714 with respect  
 21          to health insurance coverage offered by a health insurance  
 22          issuer and with respect to a group health plan that is a  
 23          non-Federal governmental plan.

24          “(b) DELEGATIONS.—Any department, agency, or in-  
 25          strumentality of a State to which authority is delegated

1 pursuant to an agreement entered into under this section  
 2 may, if authorized under State law and to the extent con-  
 3 sistent with such agreement, exercise the powers of the  
 4 Secretary under this title which relate to such authority.”.

5 (b) CLERICAL AMENDMENTS.—The table of contents  
 6 in section 1 of such Act is amended—

7 (1) by inserting after the item relating to sec-  
 8 tion 503 the following new items:

“Sec. 503A. Procedures for initial claims for benefits and prior authorization determinations.

“Sec. 503B. Internal appeals of claims denials.

“Sec. 503C. Independent external appeals procedures.”;

9 (2) by inserting after the item relating to sec-  
 10 tion 713 the following new item:

“Sec. 714. Patient protection standards.”; and

11 (3) by inserting after the item relating to sec-  
 12 tion 734 the following new item:

“Sec. 735. Cooperation between Federal and State authorities.”.

13 **SEC. 406. SENSE OF THE SENATE CONCERNING THE IMPOR-**  
 14 **TANCE OF CERTAIN UNPAID SERVICES.**

15 It is the sense of the Senate that the court should  
 16 consider the loss of a nonwage earning spouse or parent  
 17 as an economic loss for the purposes of this section. Fur-  
 18 thermore, the court should define the compensation for the  
 19 loss not as minimum services, but, rather, in terms that  
 20 fully compensate for the true and whole replacement cost  
 21 to the family.

**Subtitle B—Association Health  
Plans**

**SEC. 421. RULES GOVERNING ASSOCIATION HEALTH  
PLANS.**

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

**“PART 8—RULES GOVERNING ASSOCIATION HEALTH  
PLANS**

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

“(a) IN GENERAL.—For purposes of this part, the term ‘association health plan’ means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

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

“(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, in-

1 including a corporation or similar organization that  
2 operates on a cooperative basis (within the meaning  
3 of section 1381 of the Internal Revenue Code of  
4 1986)), for substantial purposes other than that of  
5 obtaining or providing medical care;

6 “(2) is established as a permanent entity which  
7 receives the active support of its members and re-  
8 quires for membership payment on a periodic basis  
9 of dues or payments necessary to maintain eligibility  
10 for membership in the sponsor; and

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

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

22 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
23 **PLANS.**

24 “(a) IN GENERAL.—The applicable authority shall  
25 prescribe by regulation, through negotiated rulemaking, a

1 procedure under which, subject to subsection (b), the ap-  
2 plicable authority shall certify association health plans  
3 which apply for certification as meeting the requirements  
4 of this part.

5 “(b) STANDARDS.—Under the procedure prescribed  
6 pursuant to subsection (a), in the case of an association  
7 health plan that provides at least one benefit option which  
8 does not consist of health insurance coverage, the applica-  
9 ble authority shall certify such plan as meeting the re-  
10 quirements of this part only if the applicable authority is  
11 satisfied that the applicable requirements of this part are  
12 met (or, upon the date on which the plan is to commence  
13 operations, will be met) with respect to the plan.

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

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

24 “(e) CLASS CERTIFICATION FOR FULLY INSURED  
25 PLANS.—The applicable authority shall establish a class

1 certification procedure for association health plans under  
2 which all benefits consist of health insurance coverage.  
3 Under such procedure, the applicable authority shall pro-  
4 vide for the granting of certification under this part to  
5 the plans in each class of such association health plans  
6 upon appropriate filing under such procedure in connec-  
7 tion with plans in such class and payment of the pre-  
8 scribed fee under section 807(a).

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

14 “(1) a plan which offered such coverage on the  
15 date of the enactment of the Bipartisan Patient Pro-  
16 tection Act,

17 “(2) a plan under which the sponsor does not  
18 restrict membership to one or more trades and busi-  
19 nesses or industries and whose eligible participating  
20 employers represent a broad cross-section of trades  
21 and businesses or industries, or

22 “(3) a plan whose eligible participating employ-  
23 ers represent one or more trades or businesses, or  
24 one or more industries, consisting of any of the fol-  
25 lowing: agriculture; equipment and automobile deal-

1       erships; barbering and cosmetology; certified public  
2       accounting practices; child care; construction; dance,  
3       theatrical and orchestra productions; disinfecting  
4       and pest control; financial services; fishing;  
5       foodservice establishments; hospitals; labor organiza-  
6       tions; logging; manufacturing (metals); mining; med-  
7       ical and dental practices; medical laboratories; pro-  
8       fessional consulting services; sanitary services; trans-  
9       portation (local and freight); warehousing; whole-  
10      saling/distributing; or any other trade or business or  
11      industry which has been indicated as having average  
12      or above-average risk or health claims experience by  
13      reason of State rate filings, denials of coverage, pro-  
14      posed premium rate levels, or other means dem-  
15      onstrated by such plan in accordance with regula-  
16      tions which the Secretary shall prescribe through ne-  
17      gotiated rulemaking.

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

20       “(a) SPONSOR.—The requirements of this subsection  
21      are met with respect to an association health plan if the  
22      sponsor has met (or is deemed under this part to have  
23      met) the requirements of section 801(b) for a continuous  
24      period of not less than 3 years ending with the date of  
25      the application for certification under this part.

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

4           “(1) FISCAL CONTROL.—The plan is operated,  
5 pursuant to a trust agreement, by a board of trust-  
6 ees which has complete fiscal control over the plan  
7 and which is responsible for all operations of the  
8 plan.

9           “(2) RULES OF OPERATION AND FINANCIAL  
10 CONTROLS.—The board of trustees has in effect  
11 rules of operation and financial controls, based on a  
12 3-year plan of operation, adequate to carry out the  
13 terms of the plan and to meet all requirements of  
14 this title applicable to the plan.

15           “(3) RULES GOVERNING RELATIONSHIP TO  
16 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
17 TORS.—

18           “(A) IN GENERAL.—Except as provided in  
19 subparagraphs (B) and (C), the members of the  
20 board of trustees are individuals selected from  
21 individuals who are the owners, officers, direc-  
22 tors, or employees of the participating employ-  
23 ers or who are partners in the participating em-  
24 ployers and actively participate in the business.

25           “(B) LIMITATION.—



1           “(i) GENERAL RULE.—Except as pro-  
2           vided in clauses (ii) and (iii), no such  
3           member is an owner, officer, director, or  
4           employee of, or partner in, a contract ad-  
5           ministrator or other service provider to the  
6           plan.

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

17          “(iii) TREATMENT OF PROVIDERS OF  
18          MEDICAL CARE.—In the case of a sponsor  
19          which is an association whose membership  
20          consists primarily of providers of medical  
21          care, clause (i) shall not apply in the case  
22          of any service provider described in sub-  
23          paragraph (A) who is a provider of medical  
24          care under the plan.

1           “(C) CERTAIN PLANS EXCLUDED.—Sub-  
2           paragraph (A) shall not apply to an association  
3           health plan which is in existence on the date of  
4           the enactment of the Bipartisan Patient Protec-  
5           tion Act.

6           “(D) SOLE AUTHORITY.—The board has  
7           sole authority under the plan to approve appli-  
8           cations for participation in the plan and to con-  
9           tract with a service provider to administer the  
10          day-to-day affairs of the plan.

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

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

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

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

4 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

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

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

9 “(B) the joint board of trustees shall be  
 10 deemed a board of trustees with respect to  
 11 which the requirements of subsection (b) are  
 12 met; and

13 “(C) the requirements of section 804 shall  
 14 be deemed met.

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

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

18 “(B) the plan is in existence on April 1,  
 19 2001, and would be described in section  
 20 3(40)(A)(i) but solely for the failure to meet  
 21 the requirements of section 3(40)(C)(ii).

22 “(3) CONSTRUCTION.—A group health plan de-  
 23 scribed in paragraph (2) shall only be treated as an  
 24 association health plan under this part if the spon-  
 25 sor of the plan applies for, and obtains, certification

1 of the plan as an association health plan under this  
2 part.

3 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
4 **MENTS.**

5 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
6 requirements of this subsection are met with respect to  
7 an association health plan if, under the terms of the  
8 plan—

9 “(1) each participating employer must be—

10 “(A) a member of the sponsor,

11 “(B) the sponsor, or

12 “(C) an affiliated member of the sponsor  
13 with respect to which the requirements of sub-  
14 section (b) are met,

15 except that, in the case of a sponsor which is a pro-  
16 fessional association or other individual-based asso-  
17 ciation, if at least one of the officers, directors, or  
18 employees of an employer, or at least one of the in-  
19 dividuals who are partners in an employer and who  
20 actively participates in the business, is a member or  
21 such an affiliated member of the sponsor, partici-  
22 pating employers may also include such employer;  
23 and

1           “(2) all individuals commencing coverage under  
2           the plan after certification under this part must  
3           be—

4                   “(A) active or retired owners (including  
5                   self-employed individuals), officers, directors, or  
6                   employees of, or partners in, participating em-  
7                   ployers; or

8                   “(B) the beneficiaries of individuals de-  
9                   scribed in subparagraph (A).

10          “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
11          PLOYEES.—In the case of an association health plan in  
12          existence on the date of the enactment of the Bipartisan  
13          Patient Protection Act, an affiliated member of the spon-  
14          sor of the plan may be offered coverage under the plan  
15          as a participating employer only if—

16                   “(1) the affiliated member was an affiliated  
17                   member on the date of certification under this part;  
18                   or

19                   “(2) during the 12-month period preceding the  
20                   date of the offering of such coverage, the affiliated  
21                   member has not maintained or contributed to a  
22                   group health plan with respect to any of its employ-  
23                   ees who would otherwise be eligible to participate in  
24                   such association health plan.

1       “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
2       quirements of this subsection are met with respect to an  
3       association health plan if, under the terms of the plan,  
4       no participating employer may provide health insurance  
5       coverage in the individual market for any employee not  
6       covered under the plan which is similar to the coverage  
7       contemporaneously provided to employees of the employer  
8       under the plan, if such exclusion of the employee from cov-  
9       erage under the plan is based on a health status-related  
10      factor with respect to the employee and such employee  
11      would, but for such exclusion on such basis, be eligible  
12      for coverage under the plan.

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

17             “(1) under the terms of the plan, all employers  
18             meeting the preceding requirements of this section  
19             are eligible to qualify as participating employers for  
20             all geographically available coverage options, unless,  
21             in the case of any such employer, participation or  
22             contribution requirements of the type referred to in  
23             section 2711 of the Public Health Service Act are  
24             not met;

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

4           “(3) the applicable requirements of sections  
5       701, 702, and 703 are met with respect to the plan.

6   **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
7                   **DOCUMENTS, CONTRIBUTION RATES, AND**  
8                   **BENEFIT OPTIONS.**

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

12           “(1) CONTENTS OF GOVERNING INSTRU-  
13     MENTS.—The instruments governing the plan in-  
14     clude a written instrument, meeting the require-  
15     ments of an instrument required under section  
16     402(a)(1), which—

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

22           “(B) provides that the sponsor of the plan  
23     is to serve as plan sponsor (referred to in sec-  
24     tion 3(16)(B)); and

1           “(C) incorporates the requirements of sec-  
2           tion 806.

3           “(2) CONTRIBUTION RATES MUST BE NON-  
4           DISCRIMINATORY.—

5           “(A) The contribution rates for any par-  
6           ticipating small employer do not vary on the  
7           basis of the claims experience of such employer  
8           and do not vary on the basis of the type of  
9           business or industry in which such employer is  
10          engaged.

11          “(B) Nothing in this title or any other pro-  
12          vision of law shall be construed to preclude an  
13          association health plan, or a health insurance  
14          issuer offering health insurance coverage in  
15          connection with an association health plan,  
16          from—

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

19                 “(ii) varying contribution rates for  
20                 small employers in a State to the extent  
21                 that such rates could vary using the same  
22                 methodology employed in such State for  
23                 regulating premium rates in the small  
24                 group market with respect to health insur-  
25                 ance coverage offered in connection with



1           bona fide associations (within the meaning  
2           of section 2791(d)(3) of the Public Health  
3           Service Act),  
4           subject to the requirements of section 702(b)  
5           relating to contribution rates.

6           “(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If  
7           any benefit option under the plan does not consist  
8           of health insurance coverage, the plan has as of the  
9           beginning of the plan year not fewer than 1,000 participants and beneficiaries.  
10           

11           “(4) MARKETING REQUIREMENTS.—

12           “(A) IN GENERAL.—If a benefit option  
13           which consists of health insurance coverage is  
14           offered under the plan, State-licensed insurance  
15           agents shall be used to distribute to small employers coverage which does not consist of  
16           health insurance coverage in a manner comparable to the manner in which such agents are  
17           used to distribute health insurance coverage.  
18           

19           “(B) STATE-LICENSED INSURANCE  
20           AGENTS.—For purposes of subparagraph (A),  
21           the term ‘State-licensed insurance agents’  
22           means one or more agents who are licensed in  
23           a State and are subject to the laws of such  
24

1 State relating to licensure, qualification, test-  
2 ing, examination, and continuing education of  
3 persons authorized to offer, sell, or solicit  
4 health insurance coverage in such State.

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

10 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
11 DESIGN BENEFIT OPTIONS.—Subject to section 514(d),  
12 nothing in this part or any provision of State law (as de-  
13 fined in section 514(c)(1)) shall be construed to preclude  
14 an association health plan, or a health insurance issuer  
15 offering health insurance coverage in connection with an  
16 association health plan, from exercising its sole discretion  
17 in selecting the specific items and services consisting of  
18 medical care to be included as benefits under such plan  
19 or coverage, except (subject to section 514) in the case  
20 of any law to the extent that it (1) prohibits an exclusion  
21 of a specific disease from such coverage, or (2) is not pre-  
22 empted under section 731(a)(1) with respect to matters  
23 governed by section 711 or 712.

1   **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
2                   **FOR SOLVENCY FOR PLANS PROVIDING**  
3                   **HEALTH BENEFITS IN ADDITION TO HEALTH**  
4                   **INSURANCE COVERAGE.**

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

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

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

12           “(A) establishes and maintains reserves  
13 with respect to such additional benefit options,  
14 in amounts recommended by the qualified actu-  
15 ary, consisting of—

16           “(i) a reserve sufficient for unearned  
17 contributions;

18           “(ii) a reserve sufficient for benefit li-  
19 abilities which have been incurred, which  
20 have not been satisfied, and for which risk  
21 of loss has not yet been transferred, and  
22 for expected administrative costs with re-  
23 spect to such benefit liabilities;

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

1                   “(iv) a reserve sufficient for a margin  
2                   of error and other fluctuations, taking into  
3                   account the specific circumstances of the  
4                   plan; and

5                   “(B) establishes and maintains aggregate  
6                   and specific excess/stop loss insurance and sol-  
7                   vency indemnification, with respect to such ad-  
8                   ditional benefit options for which risk of loss  
9                   has not yet been transferred, as follows:

10                   “(i) The plan shall secure aggregate  
11                   excess/stop loss insurance for the plan  
12                   with an attachment point which is not  
13                   greater than 125 percent of expected gross  
14                   annual claims. The applicable authority  
15                   may by regulation, through negotiated  
16                   rulemaking, provide for upward adjust-  
17                   ments in the amount of such percentage in  
18                   specified circumstances in which the plan  
19                   specifically provides for and maintains re-  
20                   serves in excess of the amounts required  
21                   under subparagraph (A).

22                   “(ii) The plan shall secure specific ex-  
23                   cess/stop loss insurance for the plan with  
24                   an attachment point which is at least equal  
25                   to an amount recommended by the plan’s

1 qualified actuary. The applicable authority  
2 may by regulation, through negotiated  
3 rulemaking, provide for adjustments in the  
4 amount of such insurance in specified cir-  
5 cumstances in which the plan specifically  
6 provides for and maintains reserves in ex-  
7 cess of the amounts required under sub-  
8 paragraph (A).

9 “(iii) The plan shall secure indem-  
10 nification insurance for any claims which  
11 the plan is unable to satisfy by reason of  
12 a plan termination.

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

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

24 “(1) \$500,000, or

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

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

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

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

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

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

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

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

1           \$5,000, and, in addition to such annual pay-  
2           ments, such supplemental payments as the Sec-  
3           retary may determine to be necessary under  
4           paragraph (2). Payments under this paragraph  
5           are payable to the Fund at the time determined  
6           by the Secretary. Initial payments are due in  
7           advance of certification under this part. Pay-  
8           ments shall continue to accrue until a plan's as-  
9           sets are distributed pursuant to a termination  
10          procedure.

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

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

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



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

20 “(3) ASSOCIATION HEALTH PLAN FUND.—

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

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

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

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

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

19 “(A) under which an insurer (meeting such  
20 minimum standards as the applicable authority  
21 may prescribe by regulation through negotiated  
22 rulemaking) provides for payment to the plan  
23 with respect to aggregate claims under the plan  
24 in excess of an amount or amounts specified in  
25 such contract;

1 “(B) which is guaranteed renewable; and

2 “(C) which allows for payment of pre-  
3 miums by any third party on behalf of the in-  
4 sured plan.

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

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

17 “(B) which is guaranteed renewable; and

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

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

1           “(1) under which an insurer (meeting such min-  
2           imum standards as the applicable authority may pre-  
3           scribe through negotiated rulemaking) provides for  
4           payment to the plan with respect to claims under the  
5           plan which the plan is unable to satisfy by reason  
6           of a termination pursuant to section 809(b) (relating  
7           to mandatory termination);

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

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

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

20          “(j) SOLVENCY STANDARDS WORKING GROUP.—

21                 “(1) IN GENERAL.—Within 90 days after the  
22                 date of the enactment of the Bipartisan Patient Pro-  
23                 tection Act, the applicable authority shall establish a  
24                 Solvency Standards Working Group. In prescribing  
25                 the initial regulations under this section, the applica-

1        ble authority shall take into account the rec-  
2        ommendations of such Working Group.

3            “(2) MEMBERSHIP.—The Working Group shall  
4        consist of not more than 15 members appointed by  
5        the applicable authority. The applicable authority  
6        shall include among persons invited to membership  
7        on the Working Group at least one of each of the  
8        following:

9            “(A) a representative of the National Asso-  
10        ciation of Insurance Commissioners;

11           “(B) a representative of the American  
12        Academy of Actuaries;

13           “(C) a representative of the State govern-  
14        ments, or their interests;

15           “(D) a representative of existing self-in-  
16        sured arrangements, or their interests;

17           “(E) a representative of associations of the  
18        type referred to in section 801(b)(1), or their  
19        interests; and

20           “(F) a representative of multiemployer  
21        plans that are group health plans, or their in-  
22        terests.

1 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**  
2 **LATED REQUIREMENTS.**

3 “(a) **FILING FEE.**—Under the procedure prescribed  
4 pursuant to section 802(a), an association health plan  
5 shall pay to the applicable authority at the time of filing  
6 an application for certification under this part a filing fee  
7 in the amount of \$5,000, which shall be available in the  
8 case of the Secretary, to the extent provided in appropria-  
9 tion Acts, for the sole purpose of administering the certifi-  
10 cation procedures applicable with respect to association  
11 health plans.

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

18 “(1) **IDENTIFYING INFORMATION.**—The names  
19 and addresses of—

20 “(A) the sponsor; and

21 “(B) the members of the board of trustees  
22 of the plan.

23 “(2) **STATES IN WHICH PLAN INTENDS TO DO**  
24 **BUSINESS.**—The States in which participants and  
25 beneficiaries under the plan are to be located and

1 the number of them expected to be located in each  
2 such State.

3 “(3) BONDING REQUIREMENTS.—Evidence pro-  
4 vided by the board of trustees that the bonding re-  
5 quirements of section 412 will be met as of the date  
6 of the application or (if later) commencement of op-  
7 erations.

8 “(4) PLAN DOCUMENTS.—A copy of the docu-  
9 ments governing the plan (including any bylaws and  
10 trust agreements), the summary plan description,  
11 and other material describing the benefits that will  
12 be provided to participants and beneficiaries under  
13 the plan.

14 “(5) AGREEMENTS WITH SERVICE PRO-  
15 VIDERS.—A copy of any agreements between the  
16 plan and contract administrators and other service  
17 providers.

18 “(6) FUNDING REPORT.—In the case of asso-  
19 ciation health plans providing benefits options in ad-  
20 dition to health insurance coverage, a report setting  
21 forth information with respect to such additional  
22 benefit options determined as of a date within the  
23 120-day period ending with the date of the applica-  
24 tion, including the following:

1           “(A) RESERVES.—A statement, certified  
2           by the board of trustees of the plan, and a  
3           statement of actuarial opinion, signed by a  
4           qualified actuary, that all applicable require-  
5           ments of section 806 are or will be met in ac-  
6           cordance with regulations which the applicable  
7           authority shall prescribe through negotiated  
8           rulemaking.

9           “(B) ADEQUACY OF CONTRIBUTION  
10          RATES.—A statement of actuarial opinion,  
11          signed by a qualified actuary, which sets forth  
12          a description of the extent to which contribution  
13          rates are adequate to provide for the payment  
14          of all obligations and the maintenance of re-  
15          quired reserves under the plan for the 12-  
16          month period beginning with such date within  
17          such 120-day period, taking into account the  
18          expected coverage and experience of the plan. If  
19          the contribution rates are not fully adequate,  
20          the statement of actuarial opinion shall indicate  
21          the extent to which the rates are inadequate  
22          and the changes needed to ensure adequacy.

23          “(C) CURRENT AND PROJECTED VALUE OF  
24          ASSETS AND LIABILITIES.—A statement of ac-  
25          tuarial opinion signed by a qualified actuary,



1           which sets forth the current value of the assets  
2           and liabilities accumulated under the plan and  
3           a projection of the assets, liabilities, income,  
4           and expenses of the plan for the 12-month pe-  
5           riod referred to in subparagraph (B). The in-  
6           come statement shall identify separately the  
7           plan’s administrative expenses and claims.

8           “(D) COSTS OF COVERAGE TO BE  
9           CHARGED AND OTHER EXPENSES.—A state-  
10          ment of the costs of coverage to be charged, in-  
11          cluding an itemization of amounts for adminis-  
12          tration, reserves, and other expenses associated  
13          with the operation of the plan.

14          “(E) OTHER INFORMATION.—Any other  
15          information as may be determined by the appli-  
16          cable authority, by regulation through nego-  
17          tiated rulemaking, as necessary to carry out the  
18          purposes of this part.

19          “(c) FILING NOTICE OF CERTIFICATION WITH  
20          STATES.—A certification granted under this part to an  
21          association health plan shall not be effective unless written  
22          notice of such certification is filed with the applicable  
23          State authority of each State in which at least 25 percent  
24          of the participants and beneficiaries under the plan are  
25          located. For purposes of this subsection, an individual

1 shall be considered to be located in the State in which a  
2 known address of such individual is located or in which  
3 such individual is employed.

4 “(d) NOTICE OF MATERIAL CHANGES.—In the case  
5 of any association health plan certified under this part,  
6 descriptions of material changes in any information which  
7 was required to be submitted with the application for the  
8 certification under this part shall be filed in such form  
9 and manner as shall be prescribed by the applicable au-  
10 thority by regulation through negotiated rulemaking. The  
11 applicable authority may require by regulation, through  
12 negotiated rulemaking, prior notice of material changes  
13 with respect to specified matters which might serve as the  
14 basis for suspension or revocation of the certification.

15 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
16 SOCIATION HEALTH PLANS.—An association health plan  
17 certified under this part which provides benefit options in  
18 addition to health insurance coverage for such plan year  
19 shall meet the requirements of section 503B by filing an  
20 annual report under such section which shall include infor-  
21 mation described in subsection (b)(6) with respect to the  
22 plan year and, notwithstanding section 503C(a)(1)(A),  
23 shall be filed with the applicable authority not later than  
24 90 days after the close of the plan year (or on such later  
25 date as may be prescribed by the applicable authority).

1 The applicable authority may require by regulation  
2 through negotiated rulemaking such interim reports as it  
3 considers appropriate.

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

17 “(1) are in the aggregate reasonably related to  
18 the experience of the plan and to reasonable expecta-  
19 tions; and

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

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

1 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
2 **MINATION.**

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

7 “(1) not less than 60 days before the proposed  
8 termination date, provides to the participants and  
9 beneficiaries a written notice of intent to terminate  
10 stating that such termination is intended and the  
11 proposed termination date;

12 “(2) develops a plan for winding up the affairs  
13 of the plan in connection with such termination in  
14 a manner which will result in timely payment of all  
15 benefits for which the plan is obligated; and

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

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

21 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
22 **NATION.**

23 “(a) ACTIONS TO AVOID DEPLETION OF RE-  
24 SERVES.—An association health plan which is certified  
25 under this part and which provides benefits other than  
26 health insurance coverage shall continue to meet the re-

1 requirements of section 806, irrespective of whether such  
2 certification continues in effect. The board of trustees of  
3 such plan shall determine quarterly whether the require-  
4 ments of section 806 are met. In any case in which the  
5 board determines that there is reason to believe that there  
6 is or will be a failure to meet such requirements, or the  
7 applicable authority makes such a determination and so  
8 notifies the board, the board shall immediately notify the  
9 qualified actuary engaged by the plan, and such actuary  
10 shall, not later than the end of the next following month,  
11 make such recommendations to the board for corrective  
12 action as the actuary determines necessary to ensure com-  
13 pliance with section 806. Not later than 30 days after re-  
14 ceiving from the actuary recommendations for corrective  
15 actions, the board shall notify the applicable authority (in  
16 such form and manner as the applicable authority may  
17 prescribe by regulation through negotiated rulemaking) of  
18 such recommendations of the actuary for corrective action,  
19 together with a description of the actions (if any) that the  
20 board has taken or plans to take in response to such rec-  
21 ommendations. The board shall thereafter report to the  
22 applicable authority, in such form and frequency as the  
23 applicable authority may specify to the board, regarding  
24 corrective action taken by the board until the requirements  
25 of section 806 are met.

1       “(b) MANDATORY TERMINATION.—In any case in  
2 which—

3               “(1) the applicable authority has been notified  
4       under subsection (a) of a failure of an association  
5       health plan which is or has been certified under this  
6       part and is described in section 806(a)(2) to meet  
7       the requirements of section 806 and has not been  
8       notified by the board of trustees of the plan that  
9       corrective action has restored compliance with such  
10      requirements; and

11              “(2) the applicable authority determines that  
12      there is a reasonable expectation that the plan will  
13      continue to fail to meet the requirements of section  
14      806,

15      the board of trustees of the plan shall, at the direction  
16      of the applicable authority, terminate the plan and, in the  
17      course of the termination, take such actions as the appli-  
18      cable authority may require, including satisfying any  
19      claims referred to in section 806(a)(2)(B)(iii) and recov-  
20      ering for the plan any liability under subsection  
21      (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
22      that the affairs of the plan will be, to the maximum extent  
23      possible, wound up in a manner which will result in timely  
24      provision of all benefits for which the plan is obligated.

1 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
2 **VENT ASSOCIATION HEALTH PLANS PRO-**  
3 **VIDING HEALTH BENEFITS IN ADDITION TO**  
4 **HEALTH INSURANCE COVERAGE.**

5       “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
6 INSOLVENT PLANS.—Whenever the Secretary determines  
7 that an association health plan which is or has been cer-  
8 tified under this part and which is described in section  
9 806(a)(2) will be unable to provide benefits when due or  
10 is otherwise in a financially hazardous condition, as shall  
11 be defined by the Secretary by regulation through nego-  
12 tiated rulemaking, the Secretary shall, upon notice to the  
13 plan, apply to the appropriate United States district court  
14 for appointment of the Secretary as trustee to administer  
15 the plan for the duration of the insolvency. The plan may  
16 appear as a party and other interested persons may inter-  
17 vene in the proceedings at the discretion of the court. The  
18 court shall appoint such Secretary trustee if the court de-  
19 termines that the trusteeship is necessary to protect the  
20 interests of the participants and beneficiaries or providers  
21 of medical care or to avoid any unreasonable deterioration  
22 of the financial condition of the plan. The trusteeship of  
23 such Secretary shall continue until the conditions de-  
24 scribed in the first sentence of this subsection are rem-  
25 edied or the plan is terminated.

1       “(b) POWERS AS TRUSTEE.—The Secretary, upon  
2 appointment as trustee under subsection (a), shall have  
3 the power—

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

7           “(2) to require the transfer of all (or any part)  
8 of the assets and records of the plan to the Sec-  
9 retary as trustee;

10          “(3) to invest any assets of the plan which the  
11 Secretary holds in accordance with the provisions of  
12 the plan, regulations prescribed by the Secretary  
13 through negotiated rulemaking, and applicable provi-  
14 sions of law;

15          “(4) to require the sponsor, the plan adminis-  
16 trator, any participating employer, and any employee  
17 organization representing plan participants to fur-  
18 nish any information with respect to the plan which  
19 the Secretary as trustee may reasonably need in  
20 order to administer the plan;

21          “(5) to collect for the plan any amounts due the  
22 plan and to recover reasonable expenses of the trust-  
23 eeship;



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

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

8           “(8) to terminate the plan (or provide for its  
9           termination in accordance with section 809(b)) and  
10          liquidate the plan assets, to restore the plan to the  
11          responsibility of the sponsor, or to continue the  
12          trusteeship;

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

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

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

24                  “(1) the sponsor and plan administrator;

25                  “(2) each participant;

1           “(3) each participating employer; and

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

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

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

19      “(f) JURISDICTION OF COURT.—

20           “(1) IN GENERAL.—Upon the filing of an appli-  
21      cation for the appointment as trustee or the issuance  
22      of a decree under this section, the court to which the  
23      application is made shall have exclusive jurisdiction  
24      of the plan involved and its property wherever lo-  
25      cated with the powers, to the extent consistent with

1 the purposes of this section, of a court of the United  
2 States having jurisdiction over cases under chapter  
3 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and  
4 upon appointment by it of the Secretary as trustee,  
5 such court shall continue the stay of, any pending  
6 mortgage foreclosure, equity receivership, or other  
7 proceeding to reorganize, conserve, or liquidate the  
8 plan, the sponsor, or property of such plan or sponsor,  
9 and any other suit against any receiver, conservator,  
10 or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding  
11 to enforce a lien against property of the plan or the  
12 sponsor or any other suit against the plan or the  
13 sponsor.

14 “(2) VENUE.—An action under this section  
15 may be brought in the judicial district where the  
16 sponsor or the plan administrator resides or does  
17 business or where any asset of the plan is situated.  
18 A district court in which such action is brought may  
19 issue process with respect to such action in any  
20 other judicial district.  
21  
22  
23  
24

1       “(g) PERSONNEL.—In accordance with regulations  
2 which shall be prescribed by the Secretary through nego-  
3 tiated rulemaking, the Secretary shall appoint, retain, and  
4 compensate accountants, actuaries, and other professional  
5 service personnel as may be necessary in connection with  
6 the Secretary’s service as trustee under this section.

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

8       “(a) IN GENERAL.—Notwithstanding section 514, a  
9 State may impose by law a contribution tax on an associa-  
10 tion health plan described in section 806(a)(2), if the plan  
11 commenced operations in such State after the date of the  
12 enactment of the Bipartisan Patient Protection Act.

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

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

23               “(2) the rate of such tax does not exceed the  
24 rate of any tax imposed by such State on premiums  
25 or contributions received by insurers or health main-

1       tenance organizations for health insurance coverage  
2       offered in such State in connection with a group  
3       health plan;

4           “(3) such tax is otherwise nondiscriminatory;  
5       and

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

18   **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

20           “(1) GROUP HEALTH PLAN.—The term ‘group  
21      health plan’ has the meaning provided in section  
22      733(a)(1) (after applying subsection (b) of this sec-  
23      tion).

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

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

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

7           “(5) APPLICABLE AUTHORITY.—

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

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

16                           “(ii) if there if no State referred to in  
 17                           clause (i), the Secretary.

18           “(B) EXCEPTIONS.—

19                   “(i) JOINT AUTHORITIES.—Where  
 20                   such term appears in section 808(3), sec-  
 21                   tion 807(e) (in the first instance), section  
 22                   809(a) (in the second instance), section  
 23                   809(a) (in the fourth instance), and sec-  
 24                   tion 809(b)(1), such term means, in con-  
 25                   nection with an association health plan, the

1 Secretary and the State referred to in sub-  
2 paragraph (A)(i) (if any) in connection  
3 with such plan.

4 “(ii) REGULATORY AUTHORITIES.—

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

20 “(6) HEALTH STATUS-RELATED FACTOR.—The

21 term ‘health status-related factor’ has the meaning  
22 provided in section 733(d)(2).

23 “(7) INDIVIDUAL MARKET.—

24 “(A) IN GENERAL.—The term ‘individual  
25 market’ means the market for health insurance

1 coverage offered to individuals other than in  
2 connection with a group health plan.

3 “(B) TREATMENT OF VERY SMALL  
4 GROUPS.—

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

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

21 “(8) PARTICIPATING EMPLOYER.—The term  
22 ‘participating employer’ means, in connection with  
23 an association health plan, any employer, if any indi-  
24 vidual who is an employee of such employer, a part-  
25 ner in such employer, or a self-employed individual



1       who is such employer (or any dependent, as defined  
2       under the terms of the plan, of such individual) is  
3       or was covered under such plan in connection with  
4       the status of such individual as such an employee,  
5       partner, or self-employed individual in relation to the  
6       plan.

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

14              “(10) QUALIFIED ACTUARY.—The term ‘quali-  
15      fied actuary’ means an individual who is a member  
16      of the American Academy of Actuaries or meets  
17      such reasonable standards and qualifications as the  
18      Secretary may provide by regulation through nego-  
19      tiated rulemaking.

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

22                      “(A) a person who is otherwise eligible to  
23                      be a member of the sponsor but who elects an  
24                      affiliated status with the sponsor,

1           “(B) in the case of a sponsor with mem-  
2           bers which consist of associations, a person who  
3           is a member of any such association and elects  
4           an affiliated status with the sponsor, or

5           “(C) in the case of an association health  
6           plan in existence on the date of the enactment  
7           of the Bipartisan Patient Protection Act, a per-  
8           son eligible to be a member of the sponsor or  
9           one of its member associations.

10          “(12) LARGE EMPLOYER.—The term ‘large em-  
11          ployer’ means, in connection with a group health  
12          plan with respect to a plan year, an employer who  
13          employed an average of at least 51 employees on  
14          business days during the preceding calendar year  
15          and who employs at least 2 employees on the first  
16          day of the plan year.

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

21          “(b) RULES OF CONSTRUCTION.—

22          “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
23          poses of determining whether a plan, fund, or pro-  
24          gram is an employee welfare benefit plan which is an  
25          association health plan, and for purposes of applying

1       this title in connection with such plan, fund, or pro-  
2       gram so determined to be such an employee welfare  
3       benefit plan—

4               “(A) in the case of a partnership, the term  
5       ‘employer’ (as defined in section 3(5)) includes  
6       the partnership in relation to the partners, and  
7       the term ‘employee’ (as defined in section 3(6))  
8       includes any partner in relation to the partner-  
9       ship; and

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

14              “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
15       AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
16       case of any plan, fund, or program which was estab-  
17       lished or is maintained for the purpose of providing  
18       medical care (through the purchase of insurance or  
19       otherwise) for employees (or their dependents) cov-  
20       ered thereunder and which demonstrates to the Sec-  
21       retary that all requirements for certification under  
22       this part would be met with respect to such plan,  
23       fund, or program if such plan, fund, or program  
24       were a group health plan, such plan, fund, or pro-  
25       gram shall be treated for purposes of this title as an

1 employee welfare benefit plan on and after the date  
2 of such demonstration.”.

3 (b) CONFORMING AMENDMENTS TO PREEMPTION  
4 RULES.—

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

8 “(E) The preceding subparagraphs of this paragraph  
9 do not apply with respect to any State law in the case  
10 of an association health plan which is certified under part  
11 8.”.

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

14 (A) in subsection (b)(4), by striking “Sub-  
15 section (a)” and inserting “Subsections (a) and  
16 (e)”;

17 (B) in subsection (b)(5), by striking “sub-  
18 section (a)” in subparagraph (A) and inserting  
19 “subsection (a) of this section and subsections  
20 (a)(2)(B) and (b) of section 805”, and by strik-  
21 ing “subsection (a)” in subparagraph (B) and  
22 inserting “subsection (a) of this section or sub-  
23 section (a)(2)(B) or (b) of section 805”;

24 (C) by redesignating subsection (d) as sub-  
25 section (e); and

1 (D) by inserting after subsection (c) the  
2 following new subsection:

3 “(d)(1) Except as provided in subsection (b)(4), the  
4 provisions of this title shall supersede any and all State  
5 laws insofar as they may now or hereafter preclude, or  
6 have the effect of precluding, a health insurance issuer  
7 from offering health insurance coverage in connection with  
8 an association health plan which is certified under part  
9 8.

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

12 “(A) In any case in which health insurance cov-  
13 erage of any policy type is offered under an associa-  
14 tion health plan certified under part 8 to a partici-  
15 pating employer operating in such State, the provi-  
16 sions of this title shall supersede any and all laws  
17 of such State insofar as they may preclude a health  
18 insurance issuer from offering health insurance cov-  
19 erage of the same policy type to other employers op-  
20 erating in the State which are eligible for coverage  
21 under such association health plan, whether or not  
22 such other employers are participating employers in  
23 such plan.

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

1       tion health plan in a State and the filing, with the  
2       applicable State authority, of the policy form in con-  
3       nection with such policy type is approved by such  
4       State authority, the provisions of this title shall su-  
5       persede any and all laws of any other State in which  
6       health insurance coverage of such type is offered, in-  
7       sofar as they may preclude, upon the filing in the  
8       same form and manner of such policy form with the  
9       applicable State authority in such other State, the  
10      approval of the filing in such other State.

11      “(3) For additional provisions relating to association  
12      health plans, see subsections (a)(2)(B) and (b) of section  
13      805.

14      “(4) For purposes of this subsection, the term ‘asso-  
15      ciation health plan’ has the meaning provided in section  
16      801(a), and the terms ‘health insurance coverage’, ‘par-  
17      ticipating employer’, and ‘health insurance issuer’ have  
18      the meanings provided such terms in section 811, respec-  
19      tively.”.

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

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

24                       (B) in clause (ii), by inserting “and which  
25                       does not provide medical care (within the mean-

1           ing of section 733(a)(2)),” after “arrange-  
2           ment,”, and by striking “title.” and inserting  
3           “title, and”; and

4                   (C) by adding at the end the following new  
5           clause:

6           “(iii) subject to subparagraph (E), in the case  
7           of any other employee welfare benefit plan which is  
8           a multiple employer welfare arrangement and which  
9           provides medical care (within the meaning of section  
10          733(a)(2)), any law of any State which regulates in-  
11          surance may apply.”.

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

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

17                   (B) by adding at the end the following new  
18          paragraph:

19          “(2) Nothing in any other provision of law enacted  
20          on or after the date of the enactment of the Bipartisan  
21          Patient Protection Act shall be construed to alter, amend,  
22          modify, invalidate, impair, or supersede any provision of  
23          this title, except by specific cross-reference to the affected  
24          section.”.

1       (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
2 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
3 the following new sentence: “Such term also includes a  
4 person serving as the sponsor of an association health plan  
5 under part 8.”.

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

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

17       (f) REPORT TO THE CONGRESS REGARDING CERTIFI-  
18 CATION OF SELF-INSURED ASSOCIATION HEALTH  
19 PLANS.—Not later than January 1, 2006, the Secretary  
20 of Labor shall report to the Committee on Education and  
21 the Workforce of the House of Representatives and the  
22 Committee on Health, Education, Labor, and Pensions of  
23 the Senate the effect association health plans have had,  
24 if any, on reducing the number of uninsured individuals.



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

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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

5 **SEC. 422. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 6 **PLOYER ARRANGEMENTS.**

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

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

15 (2) in clause (iii)—

16 (A) by striking “common control shall not  
 17 be based on an interest of less than 25 percent”

1           and inserting “an interest of greater than 25  
2           percent may not be required as the minimum  
3           interest necessary for common control”; and

4                   (B) by striking “similar to” and inserting  
5           “consistent and coextensive with”;

6           (3) by redesignating clauses (iv) and (v) as  
7           clauses (v) and (vi), respectively; and

8           (4) by inserting after clause (iii) the following  
9           new clause:

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

1 **SEC. 423. CLARIFICATION OF TREATMENT OF CERTAIN**  
2 **COLLECTIVELY BARGAINED ARRANGE-**  
3 **MENTS.**

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

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

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

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

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

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

6           “(II) pay any type of compensation to a  
7           person, other than a full time employee of the  
8           employee organization (or a member of the or-  
9           ganization to the extent provided in regulations  
10          prescribed by the Secretary through negotiated  
11          rulemaking), that is related either to the volume  
12          or number of employers or individuals solicited  
13          or enrolled as participating employers or cov-  
14          ered individuals under the plan or other ar-  
15          rangement, or to the dollar amount or size of  
16          the contributions made by participating employ-  
17          ers or covered individuals to the plan or other  
18          arrangement;

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

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

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

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

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

1 of individuals who were covered individuals under  
2 the plan or other arrangement as of the date of the  
3 enactment of the Bipartisan Patient Protection Act  
4 and, as of the end of the preceding plan year, the  
5 number of such covered individuals does not exceed  
6 25 percent of the total number of present and  
7 former employees enrolled under the plan or other  
8 arrangement.

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

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

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

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

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

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

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

7 “(i) the plan or arrangement is in effect as of  
8 the date of the enactment of the Bipartisan Patient  
9 Protection Act; or

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

12 “(I) has been in existence for at least 3  
13 years; or

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

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

1 **SEC. 424. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
2 **CIATION HEALTH PLANS.**

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

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

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

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

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



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

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

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

9 (b) CEASE ACTIVITIES ORDERS.—Section 502 of  
10 such Act (29 U.S.C. 1132), as amended by sections 141  
11 and 143, is further amended by adding at the end the  
12 following new subsection:

13 “(p) ASSOCIATION HEALTH PLAN CEASE AND DE-  
14 SIST ORDERS.—

15 “(1) IN GENERAL.—Subject to paragraph (2),  
16 upon application by the Secretary showing the oper-  
17 ation, promotion, or marketing of an association  
18 health plan (or similar arrangement providing bene-  
19 fits consisting of medical care (as defined in section  
20 733(a)(2))) that—

21 “(A) is not certified under part 8, is sub-  
22 ject under section 514(b)(6) to the insurance  
23 laws of any State in which the plan or arrange-  
24 ment offers or provides benefits, and is not li-

1           censed, registered, or otherwise approved under  
2           the insurance laws of such State; or

3           “(B) is an association health plan certified  
4           under part 8 and is not operating in accordance  
5           with the requirements under part 8 for such  
6           certification,

7           a district court of the United States shall enter an  
8           order requiring that the plan or arrangement cease  
9           activities.

10          “(2) EXCEPTION.—Paragraph (1) shall not  
11          apply in the case of an association health plan or  
12          other arrangement if the plan or arrangement shows  
13          that—

14                 “(A) all benefits under it referred to in  
15                 paragraph (1) consist of health insurance cov-  
16                 erage; and

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

22          “(3) ADDITIONAL EQUITABLE RELIEF.—The  
23          court may grant such additional equitable relief, in-  
24          cluding any relief available under this title, as it  
25          deems necessary to protect the interests of the pub-

1       lic and of persons having claims for benefits against  
2       the plan.”.

3       (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
4       Section 503 of such Act (29 U.S.C. 1133), as amended  
5       by section 301(b), is amended by adding at the end the  
6       following new subsection:

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

13   **SEC. 425. COOPERATION BETWEEN FEDERAL AND STATE**  
14                   **AUTHORITIES.**

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

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

20               “(1) AGREEMENTS WITH STATES.—The Sec-  
21      retary shall consult with the State recognized under  
22      paragraph (2) with respect to an association health  
23      plan regarding the exercise of—

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

4           “(B) the Secretary’s authority to certify  
 5           association health plans under part 8 in accord-  
 6           ance with regulations of the Secretary applica-  
 7           ble to certification under part 8.

8           “(2) RECOGNITION OF PRIMARY DOMICILE  
 9           STATE.—In carrying out paragraph (1), the Sec-  
 10          retary shall ensure that only one State will be recog-  
 11          nized, with respect to any particular association  
 12          health plan, as the State to which consultation  
 13          is required. In carrying out this paragraph, the Sec-  
 14          retary shall take into account the places of residence  
 15          of the participants and beneficiaries under the plan  
 16          and the State in which the trust is maintained.”.

17 **SEC. 426. EFFECTIVE DATE AND TRANSITIONAL AND**  
 18 **OTHER RULES.**

19          (a) EFFECTIVE DATE.—The amendments made by  
 20          sections 421, 424, and 425 shall take effect one year from  
 21          the date of the enactment. The amendments made by sec-  
 22          tions 422 and 423 shall take effect on the date of the  
 23          enactment of this Act. The Secretary of Labor shall first  
 24          issue all regulations necessary to carry out the amend-  
 25          ments made by this subtitle within one year from the date

1 of the enactment. Such regulations shall be issued through  
2 negotiated rulemaking.

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

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

13 (1) IN GENERAL.—In any case in which, as of  
14 the date of the enactment of this Act, an arrange-  
15 ment is maintained in a State for the purpose of  
16 providing benefits consisting of medical care for the  
17 employees and beneficiaries of its participating em-  
18 ployers, at least 200 participating employers make  
19 contributions to such arrangement, such arrange-  
20 ment has been in existence for at least 10 years, and  
21 such arrangement is licensed under the laws of one  
22 or more States to provide such benefits to its par-  
23 ticipating employers, upon the filing with the appli-  
24 cable authority (as defined in section 812(a)(5) of  
25 the Employee Retirement Income Security Act of

1       1974 (as amended by this subtitle)) by the arrange-  
2       ment of an application for certification of the ar-  
3       rangement under part 8 of subtitle B of title I of  
4       such Act—

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

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

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

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

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

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

1           (E) the arrangement may be certified by  
2           any applicable authority with respect to its op-  
3           erations in any State only if it operates in such  
4           State on the date of certification.

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

10          (2) DEFINITIONS.—For purposes of this sub-  
11          section, the terms “group health plan”, “medical  
12          care”, and “participating employer” shall have the  
13          meanings provided in section 812 of the Employee  
14          Retirement Income Security Act of 1974, except  
15          that the reference in paragraph (7) of such section  
16          to an “association health plan” shall be deemed a  
17          reference to an arrangement referred to in this sub-  
18          section.

1 **TITLE V—AMENDMENTS TO THE**  
2 **INTERNAL REVENUE CODE**  
3 **OF 1986**

4 **Subtitle A—Application of Patient**  
5 **Protection Provisions**

6 **SEC. 501. APPLICATION TO GROUP HEALTH PLANS UNDER**  
7 **THE INTERNAL REVENUE CODE OF 1986.**

8 Subchapter B of chapter 100 of the Internal Revenue  
9 Code of 1986 is amended—

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

“Sec. 9813. Standard relating to patients’ bill of rights.”;

13 and

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

16 **“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF**  
17 **RIGHTS.**

18 “A group health plan shall comply with the require-  
19 ments of title I of the Bipartisan Patient Protection Act  
20 and sections 503A through 503C of the Employee Retire-  
21 ment Income Security Act of 1974 (as in effect as of the  
22 date of the enactment of such Act), and such requirements  
23 shall be deemed to be incorporated into this section.”.



1 **SEC. 502. CONFORMING ENFORCEMENT FOR WOMEN'S**  
 2 **HEALTH AND CANCER RIGHTS.**

3 Subchapter B of chapter 100 of the Internal Revenue  
 4 Code of 1986, as amended by section 501, is further  
 5 amended—

6 (1) in the table of sections, by inserting after  
 7 the item relating to section 9813 the following new  
 8 item:

“Sec. 9814. Standard relating to women’s health and cancer  
 rights.”;

9 and

10 (2) by inserting after section 9813 the fol-  
 11 lowing:

12 **“SEC. 9814. STANDARD RELATING TO WOMEN’S HEALTH**  
 13 **AND CANCER RIGHTS.**

14 “The provisions of section 713 of the Employee Re-  
 15 tirement Income Security Act of 1974 (as in effect as of  
 16 the date of the enactment of this section) shall apply to  
 17 group health plans as if included in this subchapter.”.

18 **Subtitle B—Health Care Coverage**  
 19 **Access Tax Incentives**

20 **SEC. 511. EXPANSION OF AVAILABILITY OF ARCHER MED-**  
 21 **ICAL SAVINGS ACCOUNTS.**

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

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

4           (2) CONFORMING AMENDMENTS.—

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

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

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

13                 (1) IN GENERAL.—Subparagraph (A) of section  
14       220(c)(1) of such Code (relating to eligible indi-  
15       vidual) is amended to read as follows:

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

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

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

1 “(I) which is not a high deduct-  
2 ible health plan, and

3 “(II) which provides coverage for  
4 any benefit which is covered under the  
5 high deductible health plan.”.

6 (2) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4       “(g) COST-OF-LIVING ADJUSTMENT.—

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

9           “(A) such dollar amount, multiplied by

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

15          “(2) SPECIAL RULES.—In the case of the  
16       \$1,000 amount in subsection (c)(2)(A)(i) and the  
17       \$2,000 amount in subsection (c)(2)(A)(ii), para-  
18       graph (1)(B) shall be applied by substituting ‘cal-  
19       endar year 2000’ for ‘calendar year 1997’.

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

1 (f) PROVIDING INCENTIVES FOR PREFERRED PRO-  
2 VIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS AC-  
3 COUNTS.—

4 (1) PREVENTIVE CARE COVERAGE PER-  
5 MITTED.—Clause (ii) of section 220(c)(2)(B) of such  
6 Code is amended by striking “preventive care if”  
7 and all that follows and inserting “preventive care”.

8 (2) TREATMENT OF NETWORK SERVICES.—  
9 Subparagraph (B) of section 220(c)(2) of such Code  
10 is amended by adding at the end the following new  
11 clause:

12 “(iii) TREATMENT OF NETWORK  
13 SERVICES.—In the case of a health plan  
14 which provides benefits for services pro-  
15 vided by providers in a network (as defined  
16 in section 161 of the Patient’s Bill of  
17 Rights Act of 2001) and which would  
18 (without regard to services provided by  
19 providers outside the network) be a high  
20 deductible health plan, such plan shall not  
21 fail to be a high deductible health plan  
22 because—

23 “(I) the annual deductible for  
24 services provided by providers outside  
25 the network exceeds the applicable

1 maximum dollar amount in clause (i)  
2 or (ii), or

3 “(II) the annual out-of-pocket ex-  
4 penses required to be paid for services  
5 provided by providers outside the net-  
6 work exceeds the applicable dollar  
7 amount in clause (iii).

8 The annual deductible taken into account  
9 under subsection (b)(2) with respect to a  
10 plan to which the preceding sentence ap-  
11 plies shall be the annual deductible for  
12 services provided by providers within the  
13 network.”.

14 (g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED  
15 UNDER CAFETERIA PLANS.—Subsection (f) of section  
16 125 of such Code is amended by striking “106(b),”.

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

20 **SEC. 512. DEDUCTION FOR 100 PERCENT OF HEALTH IN-**  
21 **SURANCE COSTS OF SELF-EMPLOYED INDIV-**  
22 **VIDUALS.**

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

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

9           (b) EFFECTIVE DATE.—The amendment made by  
10          this section shall apply to taxable years beginning after  
11          December 31, 2001.

12       **SEC. 513. CREDIT FOR HEALTH INSURANCE EXPENSES OF**  
13                               **SMALL BUSINESSES.**

14          (a) IN GENERAL.—Subpart D of part IV of sub-  
15          chapter A of chapter 1 of the Internal Revenue Code of  
16          1986 (relating to business-related credits) is amended by  
17          adding at the end the following:

18       **“SEC. 45E. SMALL BUSINESS HEALTH INSURANCE EX-**  
19                               **PENSES.**

20          “(a) GENERAL RULE.—For purposes of section 38,  
21          in the case of a small employer, the health insurance credit  
22          determined under this section for the taxable year is an  
23          amount equal to the applicable percentage of the expenses  
24          paid by the taxpayer during the taxable year for health



1 insurance coverage for such year provided under a new  
2 health plan for employees of such employer.

3 “(b) APPLICABLE PERCENTAGE.—For purposes of  
4 subsection (a), the applicable percentage is—

5 “(1) in the case of insurance purchased as a  
6 member of a qualified health benefit purchasing coa-  
7 lition (as defined in section 9841), 30 percent, and

8 “(2) in the case of insurance not described in  
9 paragraph (1), 20 percent.

10 “(c) LIMITATIONS.—

11 “(1) PER EMPLOYEE DOLLAR LIMITATION.—  
12 The amount of expenses taken into account under  
13 subsection (a) with respect to any employee for any  
14 taxable year shall not exceed—

15 “(A) \$2,000 in the case of self-only cov-  
16 erage, and

17 “(B) \$5,000 in the case of family coverage.

18 In the case of an employee who is covered by a new  
19 health plan of the employer for only a portion of  
20 such taxable year, the limitation under the preceding  
21 sentence shall be an amount which bears the same  
22 ratio to such limitation (determined without regard  
23 to this sentence) as such portion bears to the entire  
24 taxable year.

1           “(2) PERIOD OF COVERAGE.—Expenses may be  
2           taken into account under subsection (a) only with  
3           respect to coverage for the 4-year period beginning  
4           on the date the employer establishes a new health  
5           plan.

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

7           “(1) HEALTH INSURANCE COVERAGE.—The  
8           term ‘health insurance coverage’ has the meaning  
9           given such term by section 9832(b)(1).

10          “(2) NEW HEALTH PLAN.—

11               “(A) IN GENERAL.—The term ‘new health  
12               plan’ means any arrangement of the employer  
13               which provides health insurance coverage to em-  
14               ployees if—

15                       “(i) such employer (and any prede-  
16                       cessor employer) did not establish or main-  
17                       tain such arrangement (or any similar ar-  
18                       rangement) at any time during the 2 tax-  
19                       able years ending prior to the taxable year  
20                       in which the credit under this section is  
21                       first allowed, and

22                       “(ii) such arrangement provides  
23                       health insurance coverage to at least 70  
24                       percent of the qualified employees of such  
25                       employer.

1 “(B) QUALIFIED EMPLOYEE.—

2 “(i) IN GENERAL.—The term ‘quali-  
3 fied employee’ means any employee of an  
4 employer if the annual rate of such em-  
5 ployee’s compensation (as defined in sec-  
6 tion 414(s)) exceeds \$10,000.

7 “(ii) TREATMENT OF CERTAIN EM-  
8 PLOYEES.—The term ‘employee’ shall in-  
9 clude a leased employee within the mean-  
10 ing of section 414(n).

11 “(3) SMALL EMPLOYER.—The term ‘small em-  
12 ployer’ has the meaning given to such term by sec-  
13 tion 4980D(d)(2); except that only qualified employ-  
14 ees shall be taken into account.

15 “(e) SPECIAL RULES.—

16 “(1) CERTAIN RULES MADE APPLICABLE.—For  
17 purposes of this section, rules similar to the rules of  
18 section 52 shall apply.

19 “(2) AMOUNTS PAID UNDER SALARY REDUC-  
20 TION ARRANGEMENTS.—No amount paid or incurred  
21 pursuant to a salary reduction arrangement shall be  
22 taken into account under subsection (a).

23 “(f) TERMINATION.—This section shall not apply to  
24 expenses paid or incurred by an employer with respect to

1 any arrangement established on or after January 1,  
2 2010.”.

3 (b) CREDIT TO BE PART OF GENERAL BUSINESS  
4 CREDIT.—Section 38(b) of such Code (relating to current  
5 year business credit) is amended by striking “plus” at the  
6 end of paragraph (12), by striking the period at the end  
7 of paragraph (13) and inserting “, plus”, and by adding  
8 at the end the following:

9 “(14) in the case of a small employer (as de-  
10 fined in section 45E(d)(3)), the health insurance  
11 credit determined under section 45E(a).”.

12 (c) NO CARRYBACKS.—Subsection (d) of section 39  
13 of such Code (relating to carryback and carryforward of  
14 unused credits) is amended by adding at the end the fol-  
15 lowing:

16 “(10) NO CARRYBACK OF SECTION 45E CREDIT  
17 BEFORE EFFECTIVE DATE.—No portion of the un-  
18 used business credit for any taxable year which is  
19 attributable to the employee health insurance ex-  
20 penses credit determined under section 45E may be  
21 carried back to a taxable year ending before the date  
22 of the enactment of section 45E.”.

23 (d) DENIAL OF DOUBLE BENEFIT.—Section 280C of  
24 such Code is amended by adding at the end the following  
25 new subsection:

1       “(d) CREDIT FOR SMALL BUSINESS HEALTH INSUR-  
2   ANCE EXPENSES.—

3               “(1) IN GENERAL.—No deduction shall be al-  
4       lowed for that portion of the expenses (otherwise al-  
5       lowable as a deduction) taken into account in deter-  
6       mining the credit under section 45E for the taxable  
7       year which is equal to the amount of the credit de-  
8       termined for such taxable year under section  
9       45E(a).

10              “(2) CONTROLLED GROUPS.—Persons treated  
11       as a single employer under subsection (a) or (b) of  
12       section 52 shall be treated as 1 person for purposes  
13       of this section.”.

14       (e) CLERICAL AMENDMENT.—The table of sections  
15       for subpart D of part IV of subchapter A of chapter 1  
16       of such Code is amended by adding at the end the fol-  
17       lowing:

                  “Sec. 45E. Small business health insurance expenses.”.

18       (f) EFFECTIVE DATE.—The amendments made by  
19       this section shall apply to amounts paid or incurred in tax-  
20       able years beginning after December 31, 2001, for ar-  
21       rangements established after the date of the enactment  
22       of this Act.

1 **SEC. 514. CERTAIN GRANTS BY PRIVATE FOUNDATIONS TO**  
2 **QUALIFIED HEALTH BENEFIT PURCHASING**  
3 **COALITIONS.**

4 (a) IN GENERAL.—Section 4942 of the Internal Rev-  
5 enue Code of 1986 (relating to taxes on failure to dis-  
6 tribute income) is amended by adding at the end the fol-  
7 lowing:

8 “(k) CERTAIN QUALIFIED HEALTH BENEFIT PUR-  
9 CHASING COALITION DISTRIBUTIONS.—

10 “(1) IN GENERAL.—For purposes of subsection  
11 (g), sections 170, 501, 507, 509, and 2522, and this  
12 chapter, a qualified health benefit purchasing coali-  
13 tion distribution by a private foundation shall be  
14 considered to be a distribution for a charitable pur-  
15 pose.

16 “(2) QUALIFIED HEALTH BENEFIT PUR-  
17 CHASING COALITION DISTRIBUTION.—For purposes  
18 of paragraph (1)—

19 “(A) IN GENERAL.—The term ‘qualified  
20 health benefit purchasing coalition distribution’  
21 means any amount paid or incurred by a pri-  
22 vate foundation to or on behalf of a qualified  
23 health benefit purchasing coalition (as defined  
24 in section 9841) for purposes of payment or re-  
25 imbursement of amounts paid or incurred in

1 connection with the establishment and mainte-  
2 nance of such coalition.

3 “(B) EXCLUSIONS.—Such term shall not  
4 include any amount used by a qualified health  
5 benefit purchasing coalition (as so defined)—

6 “(i) for the purchase of real property,

7 “(ii) as payment to, or for the benefit  
8 of, members (or employees or affiliates of  
9 such members) of such coalition, or

10 “(iii) for any expense paid or incurred  
11 more than 48 months after the date of es-  
12 tablishment of such coalition.

13 “(3) TERMINATION.—This subsection shall not  
14 apply—

15 “(A) to qualified health benefit purchasing  
16 coalition distributions paid or incurred after  
17 December 31, 2009, and

18 “(B) with respect to start-up costs of a co-  
19 alition which are paid or incurred after Decem-  
20 ber 31, 2010.”.

21 (b) QUALIFIED HEALTH BENEFIT PURCHASING CO-  
22 ALITION.—

23 (1) IN GENERAL.—Chapter 100 of such Code  
24 (relating to group health plan requirements) is

1 amended by adding at the end the following new  
2 subchapter:

3 **“Subchapter D—Qualified Health Benefit**  
4 **Purchasing Coalition**

“Sec. 9841. Qualified health benefit purchasing coalition.

5 **“SEC. 9841. QUALIFIED HEALTH BENEFIT PURCHASING CO-**  
6 **ALITION.**

7 “(a) IN GENERAL.—A qualified health benefit pur-  
8 chasing coalition is a private not-for-profit corporation  
9 which—

10 “(1) sells health insurance through State li-  
11 censed health insurance issuers in the State in which  
12 the employers to which such coalition is providing  
13 insurance are located, and

14 “(2) establishes to the Secretary, under State  
15 certification procedures or other procedures as the  
16 Secretary may provide by regulation, that such coali-  
17 tion meets the requirements of this section.

18 “(b) BOARD OF DIRECTORS.—

19 “(1) IN GENERAL.—Each purchasing coalition  
20 under this section shall be governed by a Board of  
21 Directors.

22 “(2) ELECTION.—The Secretary shall establish  
23 procedures governing election of such Board.



1           “(3) MEMBERSHIP.—The Board of Directors  
2 shall—

3           “(A) be composed of representatives of the  
4 members of the coalition, in equal number, in-  
5 cluding small employers and employee rep-  
6 resentatives of such employers, but

7           “(B) not include other interested parties,  
8 such as service providers, health insurers, or in-  
9 surance agents or brokers which may have a  
10 conflict of interest with the purposes of the coa-  
11 lition.

12       “(c) MEMBERSHIP OF COALITION.—

13           “(1) IN GENERAL.—A purchasing coalition  
14 shall accept all small employers residing within the  
15 area served by the coalition as members if such em-  
16 ployers request such membership.

17           “(2) OTHER MEMBERS.—The coalition, at the  
18 discretion of its Board of Directors, may be open to  
19 individuals and large employers.

20           “(3) VOTING.—Members of a purchasing coali-  
21 tion shall have voting rights consistent with the rules  
22 established by the State.

23       “(d) DUTIES OF PURCHASING COALITIONS.—Each  
24 purchasing coalition shall—

1           “(1) enter into agreements with small employ-  
2           ers (and, at the discretion of its Board, with individ-  
3           uals and other employers) to provide health insur-  
4           ance benefits to employees and retirees of such em-  
5           ployers,

6           “(2) where feasible, enter into agreements with  
7           3 or more unaffiliated, qualified licensed health  
8           plans, to offer benefits to members,

9           “(3) offer to members at least 1 open enroll-  
10          ment period of at least 30 days per calendar year,

11          “(4) serve a significant geographical area and  
12          market to all eligible members in that area, and

13          “(5) carry out other functions provided for  
14          under this section.

15          “(e) LIMITATION ON ACTIVITIES.—A purchasing coa-  
16          lition shall not—

17               “(1) perform any activity (including certifi-  
18               cation or enforcement) relating to compliance or li-  
19               censing of health plans,

20               “(2) assume insurance or financial risk in rela-  
21               tion to any health plan, or

22               “(3) perform other activities identified by the  
23               State as being inconsistent with the performance of  
24               its duties under this section.

1       “(f) ADDITIONAL REQUIREMENTS FOR PURCHASING  
2 COALITIONS.—As provided by the Secretary in regula-  
3 tions, a purchasing coalition shall be subject to require-  
4 ments similar to the requirements of a group health plan  
5 under this chapter.

6       “(g) RELATION TO OTHER LAWS.—

7           “(1) PREEMPTION OF STATE FICTITIOUS  
8 GROUP LAWS.—Requirements (commonly referred to  
9 as fictitious group laws) relating to grouping and  
10 similar requirements for health insurance coverage  
11 are preempted to the extent such requirements im-  
12 pede the establishment and operation of qualified  
13 health benefit purchasing coalitions.

14           “(2) ALLOWING SAVINGS TO BE PASSED  
15 THROUGH.—Any State law that prohibits health in-  
16 surance issuers from reducing premiums on health  
17 insurance coverage sold through a qualified health  
18 benefit purchasing coalition to reflect administrative  
19 savings is preempted. This paragraph shall not be  
20 construed to preempt State laws that impose restric-  
21 tions on premiums based on health status, claims  
22 history, industry, age, gender, or other underwriting  
23 factors.

24           “(3) NO WAIVER OF HIPAA REQUIREMENTS.—  
25 Nothing in this section shall be construed to change

1 the obligation of health insurance issuers to comply  
2 with the requirements of title XXVII of the Public  
3 Health Service Act with respect to health insurance  
4 coverage offered to small employers in the small  
5 group market through a qualified health benefit pur-  
6 chasing coalition.

7 “(h) DEFINITION OF SMALL EMPLOYER.—For pur-  
8 poses of this section—

9 “(1) IN GENERAL.—The term ‘small employer’  
10 means, with respect to any calendar year, any em-  
11 ployer if such employer employed an average of at  
12 least 2 and not more than 50 qualified employees on  
13 business days during either of the 2 preceding cal-  
14 endar years. For purposes of the preceding sentence,  
15 a preceding calendar year may be taken into account  
16 only if the employer was in existence throughout  
17 such year.

18 “(2) EMPLOYERS NOT IN EXISTENCE IN PRE-  
19 CEDING YEAR.—In the case of an employer which  
20 was not in existence throughout the 1st preceding  
21 calendar year, the determination under paragraph  
22 (1) shall be based on the average number of quali-  
23 fied employees that it is reasonably expected such  
24 employer will employ on business days in the current  
25 calendar year.”.

1           (2) CONFORMING AMENDMENT.—The table of  
2           subchapters for chapter 100 of such Code is amend-  
3           ed by adding at the end the following item:

          “Subchapter D. Qualified health benefit purchasing coalition.”.

4           (c) EFFECTIVE DATE.—The amendment made by  
5           subsection (a) shall apply to taxable years beginning after  
6           December 31, 2001.

7   **SEC. 515. STATE GRANT PROGRAM FOR MARKET INNOVA-**  
8                           **TION.**

9           (a) IN GENERAL.—The Secretary of Health and  
10          Human Services (in this section referred to as the “Sec-  
11          retary”) shall establish a program (in this section referred  
12          to as the “program”) to award demonstration grants  
13          under this section to States to allow States to demonstrate  
14          the effectiveness of innovative ways to increase access to  
15          health insurance through market reforms and other inno-  
16          vative means. Such innovative means may include (and are  
17          not limited to) any of the following:

18               (1) Alternative group purchasing or pooling ar-  
19               rangements, such as purchasing cooperatives for  
20               small businesses, reinsurance pools, or high risk  
21               pools.

22               (2) Individual or small group market reforms.

23               (3) Consumer education and outreach.

24               (4) Subsidies to individuals, employers, or both,  
25               in obtaining health insurance.

1 (b) SCOPE; DURATION.—The program shall be lim-  
2 ited to not more than 10 States and to a total period of  
3 5 years, beginning on the date the first demonstration  
4 grant is made.

5 (c) CONDITIONS FOR DEMONSTRATION GRANTS.—

6 (1) IN GENERAL.—The Secretary may not pro-  
7 vide for a demonstration grant to a State under the  
8 program unless the Secretary finds that under the  
9 proposed demonstration grant—

10 (A) the State will provide for demonstrated  
11 increase of access for some portion of the exist-  
12 ing uninsured population through a market in-  
13 novation (other than merely through a financial  
14 expansion of a program initiated before the  
15 date of the enactment of this Act);

16 (B) the State will comply with applicable  
17 Federal laws;

18 (C) the State will not discriminate among  
19 participants on the basis of any health status-  
20 related factor (as defined in section 2791(d)(9)  
21 of the Public Health Service Act), except to the  
22 extent a State wishes to focus on populations  
23 that otherwise would not obtain health insur-  
24 ance because of such factors; and

1 (D) the State will provide for such evalua-  
2 tion, in coordination with the evaluation re-  
3 quired under subsection (d), as the Secretary  
4 may specify.

5 (2) APPLICATION.—The Secretary shall not  
6 provide a demonstration grant under the program to  
7 a State unless—

8 (A) the State submits to the Secretary  
9 such an application, in such a form and man-  
10 ner, as the Secretary specifies;

11 (B) the application includes information  
12 regarding how the demonstration grant will ad-  
13 dress issues such as governance, targeted popu-  
14 lation, expected cost, and the continuation after  
15 the completion of the demonstration grant pe-  
16 riod; and

17 (C) the Secretary determines that the dem-  
18 onstration grant will be used consistent with  
19 this section.

20 (3) FOCUS.—A demonstration grant proposal  
21 under section need not cover all uninsured individ-  
22 uals in a State or all health care benefits with re-  
23 spect to such individuals.

24 (d) EVALUATION.—The Secretary shall enter into a  
25 contract with an appropriate entity outside the Depart-

1 ment of Health and Human Services to conduct an overall  
2 evaluation of the program at the end of the program pe-  
3 riod. Such evaluation shall include an analysis of improve-  
4 ments in access, costs, quality of care, or choice of cov-  
5 erage, under different demonstration grants.

6 (e) OPTION TO PROVIDE FOR INITIAL PLANNING  
7 GRANTS.—Notwithstanding the previous provisions of this  
8 section, under the program the Secretary may provide for  
9 a portion of the amounts appropriated under subsection  
10 (f) (not to exceed \$5,000,000) to be made available to any  
11 State for initial planning grants to permit States to de-  
12 velop demonstration grant proposals under the previous  
13 provisions of this section.

14 (f) AUTHORIZATION OF APPROPRIATIONS.—There  
15 are authorized to be appropriated \$100,000,000 for each  
16 fiscal year to carry out this section. Amounts appropriated  
17 under this subsection shall remain available until ex-  
18 pended.

19 (g) STATE DEFINED.—For purposes of this section,  
20 the term “State” has the meaning given such term for  
21 purposes of title XIX of the Social Security Act.



1 **TITLE VI—EFFECTIVE DATES;**  
2 **COORDINATION IN IMPLE-**  
3 **MENTATION**

4 **SEC. 601. EFFECTIVE DATES.**

5 (a) GROUP HEALTH COVERAGE.—

6 (1) IN GENERAL.—Subject to paragraph (2)  
7 and subsection (d), the amendments made by sec-  
8 tions 201(a), 401, 403, 501, and 502 (and title I in-  
9 sofar as it relates to such sections) shall apply with  
10 respect to group health plans, and health insurance  
11 coverage offered in connection with group health  
12 plans, for plan years beginning on or after October  
13 1, 2002 (in this section referred to as the “general  
14 effective date”).

15 (2) TREATMENT OF COLLECTIVE BARGAINING  
16 AGREEMENTS.—In the case of a group health plan  
17 maintained pursuant to one or more collective bar-  
18 gaining agreements between employee representa-  
19 tives and one or more employers ratified before the  
20 date of the enactment of this Act, the amendments  
21 made by sections 201(a), 401, 403, 501, and 502  
22 (and title I insofar as it relates to such sections)  
23 shall not apply to plan years beginning before the  
24 later of—

1           (A) the date on which the last collective  
2           bargaining agreements relating to the plan ter-  
3           minates (excluding any extension thereof agreed  
4           to after the date of the enactment of this Act);  
5           or

6           (B) the general effective date,  
7           but shall apply not later than 1 year after the gen-  
8           eral effective date. For purposes of subparagraph  
9           (A), any plan amendment made pursuant to a collec-  
10          tive bargaining agreement relating to the plan which  
11          amends the plan solely to conform to any require-  
12          ment added by this Act shall not be treated as a ter-  
13          mination of such collective bargaining agreement.

14          (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—  
15          Subject to subsection (d), the amendments made by sec-  
16          tion 202 shall apply with respect to individual health in-  
17          surance coverage offered, sold, issued, renewed, in effect,  
18          or operated in the individual market on or after the gen-  
19          eral effective date.

20          (c) TREATMENT OF RELIGIOUS NONMEDICAL PRO-  
21          VIDERS.—

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

24                       (A) restrict or limit the right of group  
25                       health plans, and of health insurance issuers of-

1           fering health insurance coverage, to include as  
2           providers religious nonmedical providers;

3           (B) require such plans or issuers to—

4                 (i) utilize medically based eligibility  
5                 standards or criteria in deciding provider  
6                 status of religious nonmedical providers;

7                 (ii) use medical professionals or cri-  
8                 teria to decide patient access to religious  
9                 nonmedical providers;

10                (iii) utilize medical professionals or  
11                criteria in making decisions in internal or  
12                external appeals regarding coverage for  
13                care by religious nonmedical providers; or

14                (iv) compel a participant or bene-  
15                ficiary to undergo a medical examination  
16                or test as a condition of receiving health  
17                insurance coverage for treatment by a reli-  
18                gious nonmedical provider; or

19           (C) require such plans or issuers to ex-  
20           clude religious nonmedical providers because  
21           they do not provide medical or other required  
22           data, if such data is inconsistent with the reli-  
23           gious nonmedical treatment or nursing care  
24           provided by the provider.

1           (2) RELIGIOUS NONMEDICAL PROVIDER.—For  
2       purposes of this subsection, the term “religious non-  
3       medical provider” means a provider who provides no  
4       medical care but who provides only religious non-  
5       medical treatment or religious nonmedical nursing  
6       care.

7       (d) TRANSITION FOR NOTICE REQUIREMENT.—The  
8       disclosure of information required under section 121 of  
9       this Act shall first be provided pursuant to—

10           (1) subsection (a) with respect to a group  
11       health plan that is maintained as of the general ef-  
12       fective date, not later than 30 days before the begin-  
13       ning of the first plan year to which title I applies  
14       in connection with the plan under such subsection;  
15       or

16           (2) subsection (b) with respect to a individual  
17       health insurance coverage that is in effect as of the  
18       general effective date, not later than 30 days before  
19       the first date as of which title I applies to the cov-  
20       erage under such subsection.

21   **SEC. 602. COORDINATION IN IMPLEMENTATION.**

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

1           (1) regulations, rulings, and interpretations  
2       issued by such Secretaries relating to the same mat-  
3       ter over which such Secretaries have responsibility  
4       under the provisions of this Act (and the amend-  
5       ments made thereby) are administered so as to have  
6       the same effect at all times; and

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

12 **SEC. 603. SEVERABILITY.**

13       (a) IN GENERAL.—Except as provided in subsections  
14 (b) and (c), if any provision of this Act, an amendment  
15 made by this Act, or the application of such provision or  
16 amendment to any person or circumstance is held to be  
17 unconstitutional, the remainder of this Act, the amend-  
18 ments made by this Act, and the application of the provi-  
19 sions of such to any person or circumstance shall not be  
20 affected thereby.

21       (b) DEPENDENCE OF REMEDIES ON APPEALS.—If  
22 any provision of section 503A, 503B, or 503C of the Em-  
23 ployee Retirement Income Security Act of 1974 (as in-  
24 serted by section 131) or the application of either such  
25 section to any person or circumstance is held to be uncon-

stitutional, section 502(n) of such Act (as inserted by section 402) shall be deemed to be null and void and shall be given no force or effect.

(c) REMEDIES.—If any provision of section 502(n) of the Employee Retirement Income Security Act of 1974 (as inserted by section 402), or the application of such section to any person or circumstance, is held to be unconstitutional, the remainder of such section shall be deemed to be null and void and shall be given no force or effect.

## **TITLE VII—MISCELLANEOUS PROVISIONS**

### **SEC. 701. NO IMPACT ON SOCIAL SECURITY TRUST FUNDS.**

(a) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(b) TRANSFERS.—

(1) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this Act has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates

1       that the enactment of this Act has a negative impact  
2       on the income and balances of the trust funds estab-  
3       lished under section 201 of the Social Security Act  
4       (42 U.S.C. 401), the Secretary shall transfer, not  
5       less frequently than quarterly, from the general reve-  
6       nues of the Federal Government an amount suffi-  
7       cient so as to ensure that the income and balances  
8       of such trust funds are not reduced as a result of  
9       the enactment of such Act.

10 **SEC. 702. CUSTOMS USER FEES.**

11       Section 13031(j)(3) of the Consolidated Omnibus  
12 Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3))  
13 is amended by striking “2003” and inserting “2011, ex-  
14 cept that fees may not be charged under paragraphs (9)  
15 and (10) of such subsection after March 31, 2006”.

16 **SEC. 703. FISCAL YEAR 2002 MEDICARE PAYMENTS.**

17       Notwithstanding any other provision of law, any let-  
18 ter of credit under part B of title XVIII of the Social Se-  
19 curity Act (42 U.S.C. 1395j et seq.) that would otherwise  
20 be sent to the Treasury or the Federal Reserve Board on  
21 September 30, 2002, by a carrier with a contract under  
22 section 1842 of that Act (42 U.S.C. 1395u) shall be sent  
23 on October 1, 2002.

1 **SEC. 704. SENSE OF THE SENATE WITH RESPECT TO PAR-**  
2 **TICIPATION IN CLINICAL TRIALS AND AC-**  
3 **CESS TO SPECIALTY CARE.**

4 (a) FINDINGS.—The Senate finds the following:

5 (1) Breast cancer is the most common form of  
6 cancer among women, excluding skin cancers.

7 (2) During 2001, 182,800 new cases of female  
8 invasive breast cancer will be diagnosed, and 40,800  
9 women will die from the disease.

10 (3) In addition, 1,400 male breast cancer cases  
11 are projected to be diagnosed, and 400 men will die  
12 from the disease.

13 (4) Breast cancer is the second leading cause of  
14 cancer death among all women and the leading  
15 cause of cancer death among women between ages  
16 40 and 55.

17 (5) This year 8,600 children are expected to be  
18 diagnosed with cancer.

19 (6) 1,500 children are expected to die from can-  
20 cer this year.

21 (7) There are approximately 333,000 people di-  
22 agnosed with multiple sclerosis in the United States  
23 and 200 more cases are diagnosed each week.

24 (8) Parkinson's disease is a progressive disorder  
25 of the central nervous system affecting 1,000,000 in  
26 the United States.



1           (9) An estimated 198,100 men will be diag-  
2       nosed with prostate cancer this year.

3           (10) 31,500 men will die from prostate cancer  
4       this year. It is the second leading cause of cancer in  
5       men.

6           (11) While information obtained from clinical  
7       trials is essential to finding cures for diseases, it is  
8       still research which carries the risk of fatal results.  
9       Future efforts should be taken to protect the health  
10      and safety of adults and children who enroll in clin-  
11      ical trials.

12          (12) While employers and health plans should  
13      be responsible for covering the routine costs associ-  
14      ated with federally approved or funded clinical trials,  
15      such employers and health plans should not be held  
16      legally responsible for the design, implementation, or  
17      outcome of such clinical trials, consistent with any  
18      applicable State or Federal liability statutes.

19      (b) SENSE OF THE SENATE.—It is the sense of the  
20      Senate that—

21          (1) men and women battling life-threatening,  
22      deadly diseases, including advanced breast or ovar-  
23      ian cancer, should have the opportunity to partici-  
24      pate in a federally approved or funded clinical trial  
25      recommended by their physician;

1           (2) an individual should have the opportunity to  
2       participate in a federally approved or funded clinical  
3       trial recommended by their physician if—

4           (A) that individual—

5               (i) has a life-threatening or serious ill-  
6               ness for which no standard treatment is ef-  
7               fective;

8               (ii) is eligible to participate in a feder-  
9               ally approved or funded clinical trial ac-  
10              cording to the trial protocol with respect to  
11              treatment of the illness;

12           (B) that individual's participation in the  
13       trial offers meaningful potential for significant  
14       clinical benefit for the individual; and

15           (C) either—

16               (i) the referring physician is a partici-  
17               pating health care professional and has  
18               concluded that the individual's participa-  
19               tion in the trial would be appropriate,  
20               based upon the individual meeting the con-  
21               ditions described in subparagraph (A); or

22               (ii) the participant, beneficiary, or en-  
23               rollee provides medical and scientific infor-  
24               mation establishing that the individual's  
25               participation in the trial would be appro-

1           priate, based upon the individual meeting  
2           the conditions described in subparagraph  
3           (A);

4           (3) a child with a life-threatening illness, in-  
5           cluding cancer, should be allowed to participate in a  
6           federally approved or funded clinical trial if that  
7           participation meets the requirements of paragraph  
8           (2);

9           (4) a child with a rare cancer should be allowed  
10          to go to a cancer center capable of providing high  
11          quality care for that disease; and

12          (5) a health maintenance organization's deci-  
13          sion that an in-network physician without the nec-  
14          essary expertise can provide care for a seriously ill  
15          patient, including a woman battling cancer, should  
16          be appealable to an independent, impartial body, and  
17          that this same right should be available to all Ameri-  
18          cans in need of access to high quality specialty care.

19 **SEC. 705. SENSE OF THE SENATE REGARDING FAIR REVIEW**  
20 **PROCESS.**

21          (a) FINDINGS.—The Senate finds the following:

22               (1) A fair, timely, impartial independent exter-  
23               nal appeals process is essential to any meaningful  
24               program of patient protection.

1           (2) The independence and objectivity of the re-  
2       view organization and review process must be en-  
3       sured.

4           (3) It is incompatible with a fair and inde-  
5       pendent appeals process to allow a health mainte-  
6       nance organization to select the review organization  
7       that is entrusted with providing a neutral and unbi-  
8       ased medical review.

9           (4) The American Arbitration Association and  
10      arbitration standards adopted under chapter 44 of  
11      title 28, United States Code (28 U.S.C. 651 et seq.)  
12      both prohibit, as inherently unfair, the right of one  
13      party to a dispute to choose the judge in that dis-  
14      pute.

15      (b) SENSE OF THE SENATE.—It is the sense of the  
16      Senate that—

17           (1) every patient who is denied care by a health  
18      maintenance organization or other health insurance  
19      company should be entitled to a fair, speedy, impar-  
20      tial appeal to a review organization that has not  
21      been selected by the health plan;

22           (2) the States should be empowered to maintain  
23      and develop the appropriate process for selection of  
24      the independent external review entity;

1           (3) a child battling a rare cancer whose health  
2           maintenance organization has denied a covered  
3           treatment recommended by its physician should be  
4           entitled to a fair and impartial external appeal to a  
5           review organization that has not been chosen by the  
6           organization or plan that has denied the care; and

7           (4) patient protection legislation should not pre-  
8           empt existing State laws in States where there al-  
9           ready are strong laws in place regarding the selec-  
10          tion of independent review organizations.

11 **SEC. 706. ANNUAL REVIEW.**

12          (a) IN GENERAL.—Not later than 24 months after  
13 the general effective date referred to in section 601(a)(1),  
14 and annually thereafter for each of the succeeding 4 cal-  
15 endar years (or until a repeal is effective under subsection  
16 (b)), the Secretary of Health and Human Services shall  
17 request that the Institute of Medicine of the National  
18 Academy of Sciences prepare and submit to the appro-  
19 priate committees of Congress a report concerning the im-  
20 pact of this Act, and the amendments made by this Act,  
21 on the number of individuals in the United States with  
22 health insurance coverage.

23          (b) LIMITATION WITH RESPECT TO CERTAIN  
24 PLANS.—If the Secretary, in any report submitted under  
25 subsection (a), determines that more than 1,000,000 indi-

1 viduals in the United States have lost their health insur-  
2 ance coverage as a result of the enactment of this Act,  
3 as compared to the number of individuals with health in-  
4 surance coverage in the 12-month period preceding the  
5 date of the enactment of this Act, section 402 of this Act  
6 shall be repealed effective on the date that is 12 month  
7 after the date on which the report is submitted, and the  
8 submission of any further reports under subsection (a)  
9 shall not be required.

10 (c) FUNDING.—From funds appropriated to the De-  
11 partment of Health and Human Services for fiscal years  
12 2003 and 2004, the Secretary of Health and Human Serv-  
13 ices shall provide for such funding as the Secretary deter-  
14 mines necessary for the conduct of the study of the Na-  
15 tional Academy of Sciences under this section.

16 **SEC. 707. DEFINITION OF BORN-ALIVE INFANT.**

17 (a) IN GENERAL.—Chapter 1 of title 1, United  
18 States Code, is amended by adding at the end the fol-  
19 lowing:

20 **“§ 8. ‘Person’, ‘human being’, ‘child’, and ‘individual’**  
21 **as including born-alive infant**

22 “(a) In determining the meaning of any Act of Con-  
23 gress, or of any ruling, regulation, or interpretation of the  
24 various administrative bureaus and agencies of the United  
25 States, the words ‘person’, ‘human being’, ‘child’, and ‘in-

1 individual', shall include every infant member of the species  
2 homo sapiens who is born alive at any stage of develop-  
3 ment.

4       “(b) As used in this section, the term ‘born alive’,  
5 with respect to a member of the species homo sapiens,  
6 means the complete expulsion or extraction from his or  
7 her mother of that member, at any stage of development,  
8 who after such expulsion or extraction breathes or has a  
9 beating heart, pulsation of the umbilical cord, or definite  
10 movement of voluntary muscles, regardless of whether the  
11 umbilical cord has been cut, and regardless of whether the  
12 expulsion or extraction occurs as a result of natural or  
13 induced labor, caesarean section, or induced abortion.

14       “(c) Nothing in this section shall be construed to af-  
15 firm, deny, expand, or contract any legal status or legal  
16 right applicable to any member of the species homo sapi-  
17 ens at any point prior to being born alive as defined in  
18 this section.”.

1       (b) CLERICAL AMENDMENT.—The table of sections  
2 at the beginning of chapter 1 of title 1, United States  
3 Code, is amended by adding at the end the following new  
4 item:

“8. ‘Person’, ‘human being’, ‘child’, and ‘individual’ as including born-alive in-  
fant.”.

Passed the House of Representatives August 2,  
2001.

Attest:

JEFF TRANDAHL,  
*Clerk.*





**Calendar No. 150**

107TH CONGRESS  
1ST SESSION

# **H. R. 2563**

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## **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.

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SEPTEMBER 5, 2001

Received and read the first time

SEPTEMBER 6, 2001

Read the second time and placed on the calendar