

109TH CONGRESS  
1ST SESSION

# S. 1012

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.

---

## IN THE SENATE OF THE UNITED STATES

MAY 12, 2005

Mr. KENNEDY (for himself, Mr. HARKIN, Ms. MIKULSKI, Mrs. MURRAY, Mr. REED, Mr. LEVIN, Mr. LAUTENBERG, Mrs. BOXER, Mr. DORGAN, Mr. SCHUMER, Ms. CANTWELL, Mr. CORZINE, Mr. DAYTON, and Ms. STABENOW) introduced the following bill; which was read twice and referred to the Committee on Finance

---

## A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Patients’ Bill of Rights Act of 2005”.

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

Sec. 1. Short title; table of contents.

## TITLE I—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

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. Cooperation between Federal and State authorities.

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. Credit for health insurance expenses of small businesses.

Sec. 512. Certain grants by private foundations to qualified health benefit purchasing coalitions.

Sec. 513. State grant program for market innovation.

Sec. 514. Grant program to facilitate health benefits information for small employers.

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 Fund.

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 102.

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

23 (3) UTILIZATION REVIEW DEFINED.—For pur-  
24 poses of this section, the terms “utilization review”  
25 and “utilization review activities” mean procedures

1 used to monitor or evaluate the use or coverage,  
2 clinical necessity, appropriateness, efficacy, or effi-  
3 ciency of health care services, procedures or settings,  
4 and includes prospective review, concurrent review,  
5 second opinions, case management, discharge plan-  
6 ning, or retrospective review.

7 (b) WRITTEN POLICIES AND CRITERIA.—

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

12 (2) USE OF WRITTEN CRITERIA.—

13 (A) IN GENERAL.—Such a program shall  
14 utilize written clinical review criteria developed  
15 with input from a range of appropriate actively  
16 practicing health care professionals, as deter-  
17 mined by the plan, pursuant to the program.  
18 Such criteria shall include written clinical re-  
19 view criteria that are based on valid clinical evi-  
20 dence where available and that are directed spe-  
21 cifically at meeting the needs of at-risk popu-  
22 lations and covered individuals with chronic  
23 conditions or severe illnesses, including gender-  
24 specific criteria and pediatric-specific criteria  
25 where available and appropriate.

1 (B) CONTINUING USE OF STANDARDS IN  
 2 RETROSPECTIVE REVIEW.—If a health care  
 3 service has been specifically pre-authorized or  
 4 approved for a participant, beneficiary, or en-  
 5 rollee under such a program, the program shall  
 6 not, pursuant to retrospective review, revise or  
 7 modify the specific standards, criteria, or proce-  
 8 dures used for the utilization review for proce-  
 9 dures, treatment, and services delivered to the  
 10 enrollee during the same course of treatment.

11 (C) REVIEW OF SAMPLE OF CLAIMS DENI-  
 12 ALS.—Such a program shall provide for a peri-  
 13 odic evaluation of the clinical appropriateness of  
 14 at least a sample of denials of claims for bene-  
 15 fits.

16 (c) CONDUCT OF PROGRAM ACTIVITIES.—

17 (1) ADMINISTRATION BY HEALTH CARE PRO-  
 18 FESSIONALS.—A utilization review program shall be  
 19 administered by qualified health care professionals  
 20 who shall oversee review decisions.

21 (2) USE OF QUALIFIED, INDEPENDENT PER-  
 22 SONNEL.—

23 (A) IN GENERAL.—A utilization review  
 24 program shall provide for the conduct of utiliza-  
 25 tion review activities only through personnel

1           who are qualified and have received appropriate  
2           training in the conduct of such activities under  
3           the program.

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

11                   (C) PROHIBITION OF CONFLICTS.—Such a  
12          program shall not permit a health care profes-  
13          sional who is providing health care services to  
14          an individual to perform utilization review ac-  
15          tivities in connection with the health care serv-  
16          ices being provided to the individual.

17                   (3) ACCESSIBILITY OF REVIEW.—Such a pro-  
18          gram shall provide that appropriate personnel per-  
19          forming utilization review activities under the pro-  
20          gram, including the utilization review administrator,  
21          are reasonably accessible by toll-free telephone dur-  
22          ing normal business hours to discuss patient care  
23          and allow response to telephone requests, and that  
24          appropriate provision is made to receive and respond  
25          promptly to calls received during other hours.

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

8   **SEC. 102. PROCEDURES FOR INITIAL CLAIMS FOR BENE-**  
 9                   **FITS AND PRIOR AUTHORIZATION DETER-**  
 10                  **MINATIONS.**

11       (a) PROCEDURES OF INITIAL CLAIMS FOR BENE-  
 12       FITS.—

13           (1) IN GENERAL.—A group health plan, and a  
 14       health insurance issuer offering health insurance  
 15       coverage, shall—

16           (A) make a determination on an initial  
 17       claim for benefits by a participant, beneficiary,  
 18       or enrollee (or authorized representative) re-  
 19       garding payment or coverage for items or serv-  
 20       ices under the terms and conditions of the plan  
 21       or coverage involved, including any cost-sharing  
 22       amount that the participant, beneficiary, or en-  
 23       rollee is required to pay with respect to such  
 24       claim for benefits; and



1 (B) notify a participant, beneficiary, or en-  
2 rollee (or authorized representative) and the  
3 treating health care professional involved re-  
4 garding a determination on an initial claim for  
5 benefits made under the terms and conditions  
6 of the plan or coverage, including any cost-shar-  
7 ing amounts that the participant, beneficiary,  
8 or enrollee may be required to make with re-  
9 spect to such claim for benefits, and of the  
10 right of the participant, beneficiary, or enrollee  
11 to an internal appeal under section 103.

12 (2) ACCESS TO INFORMATION.—

13 (A) TIMELY PROVISION OF NECESSARY IN-  
14 FORMATION.—With respect to an initial claim  
15 for benefits, the participant, beneficiary, or en-  
16 rollee (or authorized representative) and the  
17 treating health care professional (if any) shall  
18 provide the plan or issuer with access to infor-  
19 mation requested by the plan or issuer that is  
20 necessary to make a determination relating to  
21 the claim. Such access shall be provided not  
22 later than 5 days after the date on which the  
23 request for information is received, or, in a case  
24 described in subparagraph (B) or (C) of sub-  
25 section (b)(1), by such earlier time as may be

1           necessary to comply with the applicable timeline  
2           under such subparagraph.

3                   (B) LIMITED EFFECT OF FAILURE ON  
4           PLAN OR ISSUER'S OBLIGATIONS.—Failure of  
5           the participant, beneficiary, or enrollee to com-  
6           ply with the requirements of subparagraph (A)  
7           shall not remove the obligation of the plan or  
8           issuer to make a decision in accordance with  
9           the medical exigencies of the case and as soon  
10          as possible, based on the available information,  
11          and failure to comply with the time limit estab-  
12          lished by this paragraph shall not remove the  
13          obligation of the plan or issuer to comply with  
14          the requirements of this section.

15                   (3) ORAL REQUESTS.—In the case of a claim  
16          for benefits involving an expedited or concurrent de-  
17          termination, a participant, beneficiary, or enrollee  
18          (or authorized representative) may make an initial  
19          claim for benefits orally, but a group health plan, or  
20          health insurance issuer offering health insurance  
21          coverage, may require that the participant, bene-  
22          ficiary, or enrollee (or authorized representative)  
23          provide written confirmation of such request in a  
24          timely manner on a form provided by the plan or  
25          issuer. In the case of such an oral request for bene-

1 fits, the making of the request (and the timing of  
2 such request) shall be treated as the making at that  
3 time of a claim for such benefits without regard to  
4 whether and when a written confirmation of such re-  
5 quest is made.

6 (b) TIMELINE FOR MAKING DETERMINATIONS.—

7 (1) PRIOR AUTHORIZATION DETERMINATION.—

8 (A) IN GENERAL.—A group health plan,  
9 and a health insurance issuer offering health in-  
10 surance coverage, shall make a prior authoriza-  
11 tion determination on a claim for benefits  
12 (whether oral or written) in accordance with the  
13 medical exigencies of the case and as soon as  
14 possible, but in no case later than 14 days from  
15 the date on which the plan or issuer receives in-  
16 formation that is reasonably necessary to enable  
17 the plan or issuer to make a determination on  
18 the request for prior authorization and in no  
19 case later than 28 days after the date of the  
20 claim for benefits is received.

21 (B) EXPEDITED DETERMINATION.—Not-  
22 withstanding subparagraph (A), a group health  
23 plan, and a health insurance issuer offering  
24 health insurance coverage, shall expedite a prior  
25 authorization determination on a claim for ben-

1       efits described in such subparagraph when a re-  
 2       quest for such an expedited determination is  
 3       made by a participant, beneficiary, or enrollee  
 4       (or authorized representative) at any time dur-  
 5       ing the process for making a determination and  
 6       a health care professional certifies, with the re-  
 7       quest, that a determination under the proce-  
 8       dures described in subparagraph (A) would seri-  
 9       ously jeopardize the life or health of the partici-  
 10      pant, beneficiary, or enrollee or the ability of  
 11      the participant, beneficiary, or enrollee to main-  
 12      tain or regain maximum function. Such deter-  
 13      mination shall be made in accordance with the  
 14      medical exigencies of the case and as soon as  
 15      possible, but in no case later than 72 hours  
 16      after the time the request is received by the  
 17      plan or issuer under this subparagraph.

18                   (C) ONGOING CARE.—

19                       (i) CONCURRENT REVIEW.—

20                           (I) IN GENERAL.—Subject to  
 21                           clause (ii), in the case of a concurrent  
 22                           review of ongoing care (including hos-  
 23                           pitalization), which results in a termi-  
 24                           nation or reduction of such care, the  
 25                           plan or issuer must provide by tele-

1 phone and in printed form notice of  
2 the concurrent review determination  
3 to the individual or the individual's  
4 designee and the individual's health  
5 care provider in accordance with the  
6 medical exigencies of the case and as  
7 soon as possible, with sufficient time  
8 prior to the termination or reduction  
9 to allow for an appeal under section  
10 103(b)(3) to be completed before the  
11 termination or reduction takes effect.

12 (II) CONTENTS OF NOTICE.—

13 Such notice shall include, with respect  
14 to ongoing health care items and serv-  
15 ices, the number of ongoing services  
16 approved, the new total of approved  
17 services, the date of onset of services,  
18 and the next review date, if any, as  
19 well as a statement of the individual's  
20 rights to further appeal.

21 (ii) RULE OF CONSTRUCTION.—Clause

22 (i) shall not be construed as requiring  
23 plans or issuers to provide coverage of care  
24 that would exceed the coverage limitations  
25 for such care.

1           (2)     RETROSPECTIVE     DETERMINATION.—A  
2     group health plan, and a health insurance issuer of-  
3     fering health insurance coverage, shall make a retro-  
4     spective determination on a claim for benefits in ac-  
5     cordance with the medical exigencies of the case and  
6     as soon as possible, but not later than 30 days after  
7     the date on which the plan or issuer receives infor-  
8     mation that is reasonably necessary to enable the  
9     plan or issuer to make a determination on the claim,  
10    or, if earlier, 60 days after the date of receipt of the  
11    claim for benefits.

12       (c) NOTICE OF A DENIAL OF A CLAIM FOR BENE-  
13    FITS.—Written notice of a denial made under an initial  
14    claim for benefits shall be issued to the participant, bene-  
15    ficiary, or enrollee (or authorized representative) and the  
16    treating health care professional in accordance with the  
17    medical exigencies of the case and as soon as possible, but  
18    in no case later than 2 days after the date of the deter-  
19    mination (or, in the case described in subparagraph (B)  
20    or (C) of subsection (b)(1), within the 72-hour or applica-  
21    ble period referred to in such subparagraph).

22       (d) REQUIREMENTS OF NOTICE OF DETERMINA-  
23    TIONS.—The written notice of a denial of a claim for bene-  
24    fits determination under subsection (c) shall be provided  
25    in printed form and written in a manner calculated to be

1 understood by the participant, beneficiary, or enrollee and  
2 shall include—

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

6 (2) the procedures for obtaining additional in-  
7 formation concerning the determination; and

8 (3) notification of the right to appeal the deter-  
9 mination and instructions on how to initiate an ap-  
10 peal in accordance with section 103.

11 (e) DEFINITIONS.—For purposes of this part:

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

19 (2) CLAIM FOR BENEFITS.—The term “claim  
20 for benefits” means any request for coverage (in-  
21 cluding authorization of coverage), for eligibility, or  
22 for payment in whole or in part, for an item or serv-  
23 ice under a group health plan or health insurance  
24 coverage.

1           (3) DENIAL OF CLAIM FOR BENEFITS.—The  
 2       term “denial” means, with respect to a claim for  
 3       benefits, a denial (in whole or in part) of, or a fail-  
 4       ure to act on a timely basis upon, the claim for ben-  
 5       efits and includes a failure to provide benefits (in-  
 6       cluding items and services) required to be provided  
 7       under this title.

8           (4) TREATING HEALTH CARE PROFESSIONAL.—  
 9       The term “treating health care professional” means,  
 10      with respect to services to be provided to a partici-  
 11      pant, beneficiary, or enrollee, a health care profes-  
 12      sional who is primarily responsible for delivering  
 13      those services to the participant, beneficiary, or en-  
 14      rollee.

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

16       (a) RIGHT TO INTERNAL APPEAL.—

17           (1) IN GENERAL.—A participant, beneficiary, or  
 18       enrollee (or authorized representative) may appeal  
 19       any denial of a claim for benefits under section 102  
 20       under the procedures described in this section.

21           (2) TIME FOR APPEAL.—

22           (A) IN GENERAL.—A group health plan,  
 23       and a health insurance issuer offering health in-  
 24       surance coverage, shall ensure that a partici-  
 25       pant, beneficiary, or enrollee (or authorized rep-



representative) has a period of not less than 180 days beginning on the date of a denial of a claim for benefits under section 102 in which to appeal such denial under this section.

(B) DATE OF DENIAL.—For purposes of subparagraph (A), the date of the denial shall be deemed to be the date as of which the participant, beneficiary, or enrollee knew of the denial of the claim for benefits.

(3) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination on a claim for benefits under section 102 within the applicable timeline established for such a determination under such section is a denial of a claim for benefits for purposes this subtitle as of the date of the applicable deadline.

(4) PLAN WAIVER OF INTERNAL REVIEW.—A group health plan, or health insurance issuer offering health insurance coverage, may waive the internal review process under this section. In such case the plan or issuer shall provide notice to the participant, beneficiary, or enrollee (or authorized representative) involved, the participant, beneficiary, or enrollee (or authorized representative) involved shall be relieved of any obligation to complete the internal review involved, and may, at the option of such par-

1 participant, beneficiary, enrollee, or representative pro-  
 2 ceed directly to seek further appeal through external  
 3 review under section 104 or otherwise.

4 (b) TIMELINES FOR MAKING DETERMINATIONS.—

5 (1) ORAL REQUESTS.—In the case of an appeal  
 6 of a denial of a claim for benefits under this section  
 7 that involves an expedited or concurrent determina-  
 8 tion, a participant, beneficiary, or enrollee (or au-  
 9 thorized representative) may request such appeal  
 10 orally. A group health plan, or health insurance  
 11 issuer offering health insurance coverage, may re-  
 12 quire that the participant, beneficiary, or enrollee  
 13 (or authorized representative) provide written con-  
 14 firmation of such request in a timely manner on a  
 15 form provided by the plan or issuer. In the case of  
 16 such an oral request for an appeal of a denial, the  
 17 making of the request (and the timing of such re-  
 18 quest) shall be treated as the making at that time  
 19 of a request for an appeal without regard to whether  
 20 and when a written confirmation of such request is  
 21 made.

22 (2) ACCESS TO INFORMATION.—

23 (A) TIMELY PROVISION OF NECESSARY IN-  
 24 FORMATION.—With respect to an appeal of a  
 25 denial of a claim for benefits, the participant,

beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the appeal. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of paragraph (3), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

1           (3)   PRIOR   AUTHORIZATION   DETERMINA-  
2   TIONS.—

3           (A) IN GENERAL.—Except as provided in  
4   this paragraph or paragraph (4), a group  
5   health plan, and a health insurance issuer offer-  
6   ing health insurance coverage, shall make a de-  
7   termination on an appeal of a denial of a claim  
8   for benefits under this subsection in accordance  
9   with the medical exigencies of the case and as  
10   soon as possible, but in no case later than 14  
11   days from the date on which the plan or issuer  
12   receives information that is reasonably nec-  
13   essary to enable the plan or issuer to make a  
14   determination on the appeal and in no case  
15   later than 28 days after the date the request  
16   for the appeal is received.

17          (B) EXPEDITED DETERMINATION.—Not-  
18   withstanding subparagraph (A), a group health  
19   plan, and a health insurance issuer offering  
20   health insurance coverage, shall expedite a prior  
21   authorization determination on an appeal of a  
22   denial of a claim for benefits described in sub-  
23   paragraph (A), when a request for such an ex-  
24   pedited determination is made by a participant,  
25   beneficiary, or enrollee (or authorized represent-

1           ative) at any time during the process for mak-  
2           ing a determination and a health care profes-  
3           sional certifies, with the request, that a deter-  
4           mination under the procedures described in sub-  
5           paragraph (A) would seriously jeopardize the  
6           life or health of the participant, beneficiary, or  
7           enrollee or the ability of the participant, bene-  
8           ficiary, or enrollee to maintain or regain max-  
9           imum function. Such determination shall be  
10          made in accordance with the medical exigencies  
11          of the case and as soon as possible, but in no  
12          case later than 72 hours after the time the re-  
13          quest for such appeal is received by the plan or  
14          issuer under this subparagraph.

15               (C) ONGOING CARE DETERMINATIONS.—

16               (i) IN GENERAL.—Subject to clause  
17               (ii), in the case of a concurrent review de-  
18               termination described in section  
19               102(b)(1)(C)(i)(I), which results in a ter-  
20               mination or reduction of such care, the  
21               plan or issuer must provide notice of the  
22               determination on the appeal under this  
23               section by telephone and in printed form to  
24               the individual or the individual's designee  
25               and the individual's health care provider in

1           accordance with the medical exigencies of  
 2           the case and as soon as possible, with suf-  
 3           ficient time prior to the termination or re-  
 4           duction to allow for an external appeal  
 5           under section 104 to be completed before  
 6           the termination or reduction takes effect.

7                   (ii) RULE OF CONSTRUCTION.—Clause

8           (i) shall not be construed as requiring  
 9           plans or issuers to provide coverage of care  
 10          that would exceed the coverage limitations  
 11          for such care.

12           (4)    RETROSPECTIVE    DETERMINATION.—A

13   group health plan, and a health insurance issuer of-  
 14   fering health insurance coverage, shall make a retro-  
 15   spective determination on an appeal of a denial of a  
 16   claim for benefits in no case later than 30 days after  
 17   the date on which the plan or issuer receives nec-  
 18   essary information that is reasonably necessary to  
 19   enable the plan or issuer to make a determination on  
 20   the appeal and in no case later than 60 days after  
 21   the date the request for the appeal is received.

22           (c) CONDUCT OF REVIEW.—

23           (1) IN GENERAL.—A review of a denial of a  
 24   claim for benefits under this section shall be con-

1       ducted by an individual with appropriate expertise  
 2       who was not involved in the initial determination.

3               (2) PEER REVIEW OF MEDICAL DECISIONS BY  
 4       HEALTH CARE PROFESSIONALS.—A review of an ap-  
 5       peal of a denial of a claim for benefits that is based  
 6       on a lack of medical necessity and appropriateness,  
 7       or based on an experimental or investigational treat-  
 8       ment, or requires an evaluation of medical facts—

9               (A) shall be made by a physician  
 10       (allopathic or osteopathic); or

11              (B) in a claim for benefits provided by a  
 12       non-physician health professional, shall be made  
 13       by reviewer (or reviewers) including at least one  
 14       practicing non-physician health professional of  
 15       the same or similar specialty;

16       with appropriate expertise (including, in the case of  
 17       a child, appropriate pediatric expertise) and acting  
 18       within the appropriate scope of practice within the  
 19       State in which the service is provided or rendered,  
 20       who was not involved in the initial determination.

21       (d) NOTICE OF DETERMINATION.—

22              (1) IN GENERAL.—Written notice of a deter-  
 23       mination made under an internal appeal of a denial  
 24       of a claim for benefits shall be issued to the partici-  
 25       pant, beneficiary, or enrollee (or authorized rep-

1       representative) and the treating health care professional  
2       in accordance with the medical exigencies of the case  
3       and as soon as possible, but in no case later than  
4       2 days after the date of completion of the review (or,  
5       in the case described in subparagraph (B) or (C) of  
6       subsection (b)(3), within the 72-hour or applicable  
7       period referred to in such subparagraph).

8               (2) FINAL DETERMINATION.—The decision by a  
9       plan or issuer under this section shall be treated as  
10      the final determination of the plan or issuer on a de-  
11      nial of a claim for benefits. The failure of a plan or  
12      issuer to issue a determination on an appeal of a de-  
13      nial of a claim for benefits under this section within  
14      the applicable timeline established for such a deter-  
15      mination shall be treated as a final determination on  
16      an appeal of a denial of a claim for benefits for pur-  
17      poses of proceeding to external review under section  
18      104.

19              (3) REQUIREMENTS OF NOTICE.—With respect  
20      to a determination made under this section, the no-  
21      tice described in paragraph (1) shall be provided in  
22      printed form and written in a manner calculated to  
23      be understood by the participant, beneficiary, or en-  
24      rollee and shall include—



1 (A) the specific reasons for the determina-  
 2 tion (including a summary of the clinical or sci-  
 3 entific evidence used in making the determina-  
 4 tion);

5 (B) the procedures for obtaining additional  
 6 information concerning the determination; and

7 (C) notification of the right to an inde-  
 8 pendent external review under section 104 and  
 9 instructions on how to initiate such a review.

10 **SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCE-**  
 11 **DURES.**

12 (a) **RIGHT TO EXTERNAL APPEAL.**—A group health  
 13 plan, and a health insurance issuer offering health insur-  
 14 ance coverage, shall provide in accordance with this sec-  
 15 tion participants, beneficiaries, and enrollees (or author-  
 16 ized representatives) with access to an independent exter-  
 17 nal review for any denial of a claim for benefits.

18 (b) **INITIATION OF THE INDEPENDENT EXTERNAL**  
 19 **REVIEW PROCESS.**—

20 (1) **TIME TO FILE.**—A request for an inde-  
 21 pendent external review under this section shall be  
 22 filed with the plan or issuer not later than 180 days  
 23 after the date on which the participant, beneficiary,  
 24 or enrollee receives notice of the denial under section  
 25 103(d) or notice of waiver of internal review under

1 section 103(a)(4) or the date on which the plan or  
 2 issuer has failed to make a timely decision under  
 3 section 103(d)(2) and notifies the participant or  
 4 beneficiary that it has failed to make a timely deci-  
 5 sion and that the beneficiary must file an appeal  
 6 with an external review entity within 180 days if the  
 7 participant or beneficiary desires to file such an ap-  
 8 peal.

9 (2) FILING OF REQUEST.—

10 (A) IN GENERAL.—Subject to the suc-  
 11 ceeding provisions of this subsection, a group  
 12 health plan, or health insurance issuer offering  
 13 health insurance coverage, may—

14 (i) except as provided in subparagraph

15 (B)(i), require that a request for review be  
 16 in writing;

17 (ii) limit the filing of such a request  
 18 to the participant, beneficiary, or enrollee  
 19 involved (or an authorized representative);

20 (iii) except if waived by the plan or  
 21 issuer under section 103(a)(4), condition  
 22 access to an independent external review  
 23 under this section upon a final determina-  
 24 tion of a denial of a claim for benefits

1 under the internal review procedure under  
2 section 103;

3 (iv) except as provided in subpara-  
4 graph (B)(ii), require payment of a filing  
5 fee to the plan or issuer of a sum that does  
6 not exceed \$25; and

7 (v) require that a request for review  
8 include the consent of the participant, ben-  
9 eficiary, or enrollee (or authorized rep-  
10 resentative) for the release of necessary  
11 medical information or records of the par-  
12 ticipant, beneficiary, or enrollee to the  
13 qualified external review entity only for  
14 purposes of conducting external review ac-  
15 tivities.

16 (B) REQUIREMENTS AND EXCEPTION RE-  
17 LATING TO GENERAL RULE.—

18 (i) ORAL REQUESTS PERMITTED IN  
19 EXPEDITED OR CONCURRENT CASES.—In  
20 the case of an expedited or concurrent ex-  
21 ternal review as provided for under sub-  
22 section (e), the request for such review  
23 may be made orally. A group health plan,  
24 or health insurance issuer offering health  
25 insurance coverage, may require that the

1 participant, beneficiary, or enrollee (or au-  
2 thorized representative) provide written  
3 confirmation of such request in a timely  
4 manner on a form provided by the plan or  
5 issuer. Such written confirmation shall be  
6 treated as a consent for purposes of sub-  
7 paragraph (A)(v). In the case of such an  
8 oral request for such a review, the making  
9 of the request (and the timing of such re-  
10 quest) shall be treated as the making at  
11 that time of a request for such a review  
12 without regard to whether and when a  
13 written confirmation of such request is  
14 made.

15 (ii) EXCEPTION TO FILING FEE RE-  
16 QUIREMENT.—

17 (I) INDIGENCY.—Payment of a  
18 filing fee shall not be required under  
19 subparagraph (A)(iv) where there is a  
20 certification (in a form and manner  
21 specified in guidelines established by  
22 the appropriate Secretary) that the  
23 participant, beneficiary, or enrollee is  
24 indigent (as defined in such guide-  
25 lines).

1 (II) FEE NOT REQUIRED.—Pay-  
 2 ment of a filing fee shall not be re-  
 3 quired under subparagraph (A)(iv) if  
 4 the plan or issuer waives the internal  
 5 appeals process under section  
 6 103(a)(4).

7 (III) REFUNDING OF FEE.—The  
 8 filing fee paid under subparagraph  
 9 (A)(iv) shall be refunded if the deter-  
 10 mination under the independent exter-  
 11 nal review is to reverse or modify the  
 12 denial which is the subject of the re-  
 13 view.

14 (IV) COLLECTION OF FILING  
 15 FEE.—The failure to pay such a filing  
 16 fee shall not prevent the consideration  
 17 of a request for review but, subject to  
 18 the preceding provisions of this clause,  
 19 shall constitute a legal liability to pay.

20 (c) REFERRAL TO QUALIFIED EXTERNAL REVIEW  
 21 ENTITY UPON REQUEST.—

22 (1) IN GENERAL.—Upon the filing of a request  
 23 for independent external review with the group  
 24 health plan, or health insurance issuer offering  
 25 health insurance coverage, the plan or issuer shall

1 immediately refer such request, and forward the  
 2 plan or issuer's initial decision (including the infor-  
 3 mation described in section 103(d)(3)(A)), to a  
 4 qualified external review entity selected in accord-  
 5 ance with this section.

6 (2) ACCESS TO PLAN OR ISSUER AND HEALTH  
 7 PROFESSIONAL INFORMATION.—With respect to an  
 8 independent external review conducted under this  
 9 section, the participant, beneficiary, or enrollee (or  
 10 authorized representative), the plan or issuer, and  
 11 the treating health care professional (if any) shall  
 12 provide the external review entity with information  
 13 that is necessary to conduct a review under this sec-  
 14 tion, as determined and requested by the entity.  
 15 Such information shall be provided not later than 5  
 16 days after the date on which the request for infor-  
 17 mation is received, or, in a case described in clause  
 18 (ii) or (iii) of subsection (e)(1)(A), by such earlier  
 19 time as may be necessary to comply with the appli-  
 20 cable timeline under such clause.

21 (3) SCREENING OF REQUESTS BY QUALIFIED  
 22 EXTERNAL REVIEW ENTITIES.—

23 (A) IN GENERAL.—With respect to a re-  
 24 quest referred to a qualified external review en-  
 25 tity under paragraph (1) relating to a denial of

1 a claim for benefits, the entity shall refer such  
2 request for the conduct of an independent med-  
3 ical review unless the entity determines that—

4 (i) any of the conditions described in  
5 clauses (ii) or (iii) of subsection (b)(2)(A)  
6 have not been met;

7 (ii) the denial of the claim for benefits  
8 does not involve a medically reviewable de-  
9 cision under subsection (d)(2);

10 (iii) the denial of the claim for bene-  
11 fits relates to a decision regarding whether  
12 an individual is a participant, beneficiary,  
13 or enrollee who is enrolled under the terms  
14 and conditions of the plan or coverage (in-  
15 cluding the applicability of any waiting pe-  
16 riod under the plan or coverage); or

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

1           Upon making a determination that any of  
2           clauses (i) through (iv) applies with respect to  
3           the request, the entity shall determine that the  
4           denial of a claim for benefits involved is not eli-  
5           gible for independent medical review under sub-  
6           section (d), and shall provide notice in accord-  
7           ance with subparagraph (C).

8           (B) PROCESS FOR MAKING DETERMINA-  
9           TIONS.—

10           (i) NO DEFERENCE TO PRIOR DETER-  
11           MINATIONS.—In making determinations  
12           under subparagraph (A), there shall be no  
13           deference given to determinations made by  
14           the plan or issuer or the recommendation  
15           of a treating health care professional (if  
16           any).

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

22           (C) NOTICES AND GENERAL TIMELINES  
23           FOR DETERMINATION.—

24           (i) NOTICE IN CASE OF DENIAL OF  
25           REFERRAL.—If the entity under this para-



graph does not make a referral to an independent medical reviewer, the entity shall provide notice to the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) filing the request, and the treating health care professional (if any) that the denial is not subject to independent medical review. Such notice—

(I) shall be written (and, in addition, may be provided orally) in a manner calculated to be understood by a participant or enrollee;

(II) shall include the reasons for the determination;

(III) include any relevant terms and conditions of the plan or coverage; and

(IV) include a description of any further recourse available to the individual.

(ii) GENERAL TIMELINE FOR DETERMINATIONS.—Upon receipt of information under paragraph (2), the qualified external review entity, and if required the independent medical reviewer, shall make a de-

1            termination within the overall timeline that  
 2            is applicable to the case under review as  
 3            described in subsection (e), except that if  
 4            the entity determines that a referral to an  
 5            independent medical reviewer is not re-  
 6            quired, the entity shall provide notice of  
 7            such determination to the participant, ben-  
 8            eficiary, or enrollee (or authorized rep-  
 9            resentative) within such timeline and with-  
 10          in 2 days of the date of such determina-  
 11          tion.

12          (d) INDEPENDENT MEDICAL REVIEW.—

13            (1) IN GENERAL.—If a qualified external review  
 14          entity determines under subsection (c) that a denial  
 15          of a claim for benefits is eligible for independent  
 16          medical review, the entity shall refer the denial in-  
 17          volved to an independent medical reviewer for the  
 18          conduct of an independent medical review under this  
 19          subsection.

20            (2) MEDICALLY REVIEWABLE DECISIONS.—A  
 21          denial of a claim for benefits is eligible for inde-  
 22          pendent medical review if the benefit for the item or  
 23          service for which the claim is made would be a cov-  
 24          ered benefit under the terms and conditions of the

1 plan or coverage but for one (or more) of the fol-  
2 lowing determinations:

3 (A) DENIALS BASED ON MEDICAL NECES-  
4 SITY AND APPROPRIATENESS.—A determination  
5 that the item or service is not covered because  
6 it is not medically necessary and appropriate or  
7 based on the application of substantially equiva-  
8 lent terms.

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

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

23 (3) INDEPENDENT MEDICAL REVIEW DETER-  
24 MINATION.—

1 (A) IN GENERAL.—An independent med-  
2 ical reviewer under this section shall make a  
3 new independent determination with respect to  
4 whether or not the denial of a claim for a ben-  
5 efit that is the subject of the review should be  
6 upheld, reversed, or modified.

7 (B) STANDARD FOR DETERMINATION.—  
8 The independent medical reviewer's determina-  
9 tion relating to the medical necessity and ap-  
10 propriateness, or the experimental or investiga-  
11 tional nature, or the evaluation of the medical  
12 facts, of the item, service, or condition involved  
13 shall be based on the medical condition of the  
14 participant, beneficiary, or enrollee (including  
15 the medical records of the participant, bene-  
16 ficiary, or enrollee) and valid, relevant scientific  
17 evidence and clinical evidence, including peer-re-  
18 viewed medical literature or findings and in-  
19 cluding expert opinion.

20 (C) NO COVERAGE FOR EXCLUDED BENE-  
21 FITS.—Nothing in this subsection shall be con-  
22 strued to permit an independent medical re-  
23 viewer to require that a group health plan, or  
24 health insurance issuer offering health insur-  
25 ance coverage, provide coverage for items or

1 services for which benefits are specifically ex-  
2 cluded or expressly limited under the plan or  
3 coverage in the plain language of the plan docu-  
4 ment (and which are disclosed under section  
5 121(b)(1)(C)). Notwithstanding any other pro-  
6 vision of this Act, any exclusion of an exact  
7 medical procedure, any exact time limit on the  
8 duration or frequency of coverage, and any  
9 exact dollar limit on the amount of coverage  
10 that is specifically enumerated and defined (in  
11 the plain language of the plan or coverage docu-  
12 ments) under the plan or coverage offered by a  
13 group health plan or health insurance issuer of-  
14 fering health insurance coverage and that is  
15 disclosed under section 121(b)(1) shall be con-  
16 sidered to govern the scope of the benefits that  
17 may be required: *Provided*, That the terms and  
18 conditions of the plan or coverage relating to  
19 such an exclusion or limit are in compliance  
20 with the requirements of law.

21 (D) EVIDENCE AND INFORMATION TO BE  
22 USED IN MEDICAL REVIEWS.—In making a de-  
23 termination under this subsection, the inde-  
24 pendent medical reviewer shall also consider ap-

1           appropriate and available evidence and informa-  
 2           tion, including the following:

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

8                   (ii) The recommendation of the treat-  
 9                   ing health care professional and the evi-  
 10                  dence, guidelines, and rationale used by  
 11                  the treating health care professional in  
 12                  reaching such recommendation.

13                  (iii) Additional relevant evidence or  
 14                  information obtained by the reviewer or  
 15                  submitted by the plan, issuer, participant,  
 16                  beneficiary, or enrollee (or an authorized  
 17                  representative), or treating health care  
 18                  professional.

19                  (iv) The plan or coverage document.

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

24                   (i) consider the claim under review  
 25                   without deference to the determinations

made by the plan or issuer or the recommendation 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 REVIEWER.—An independent medical reviewer shall, in accordance with the deadlines described in subsection (e), prepare a written determination to uphold, reverse, or modify the denial under review. Such written determination shall include—

(i) the determination of the reviewer;

(ii) the specific reasons of the reviewer 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 to  
 2 reverse or modify the denial under review,  
 3 a timeframe within which the plan or  
 4 issuer must comply with such determina-  
 5 tion.

6 (G) NONBINDING NATURE OF ADDITIONAL  
 7 RECOMMENDATIONS.—In addition to the deter-  
 8 mination under subparagraph (F), the reviewer  
 9 may provide the plan or issuer and the treating  
 10 health care professional with additional rec-  
 11 ommendations in connection with such a deter-  
 12 mination, but any such recommendations shall  
 13 not affect (or be treated as part of) the deter-  
 14 mination and shall not be binding on the plan  
 15 or issuer.

16 (e) TIMELINES AND NOTIFICATIONS.—

17 (1) TIMELINES FOR INDEPENDENT MEDICAL  
 18 REVIEW.—

19 (A) PRIOR AUTHORIZATION DETERMINA-  
 20 TION.—

21 (i) IN GENERAL.—The independent  
 22 medical reviewer (or reviewers) shall make  
 23 a determination on a denial of a claim for  
 24 benefits that is referred to the reviewer  
 25 under subsection (c)(3) in accordance with



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

9 (ii) EXPEDITED DETERMINATION.—

10 Notwithstanding clause (i) and subject to  
11 clause (iii), the independent medical re-  
12 viewer (or reviewers) shall make an expe-  
13 dited determination on a denial of a claim  
14 for benefits described in clause (i), when a  
15 request for such an expedited determina-  
16 tion is made by a participant, beneficiary,  
17 or enrollee (or authorized representative)  
18 at any time during the process for making  
19 a determination, and a health care profes-  
20 sional certifies, with the request, that a de-  
21 termination under the timeline described in  
22 clause (i) would seriously jeopardize the  
23 life or health of the participant, bene-  
24 ficiary, or enrollee or the ability of the par-  
25 ticipant, beneficiary, or enrollee to main-

tain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for external review is received by the qualified external review entity.

(iii) ONGOING CARE DETERMINATION.—Notwithstanding clause (i), in the case of a review described in such clause that involves a termination or reduction of care, the notice of the determination shall be completed not later than 24 hours after the time the request for external review is received by the qualified external review entity and before the end of the approved period of care.

(B) RETROSPECTIVE DETERMINATION.—

The independent medical reviewer (or reviewers) shall complete a review in the case of a retrospective determination on an appeal of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in no case later than 30 days after the date of receipt of information under subsection (c)(2) and in no

1 case later than 60 days after the date the re-  
 2 quest for external review is received by the  
 3 qualified external review entity.

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

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

18 (1) APPLICATION OF DETERMINATIONS.—

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

24 (B) COMPLIANCE WITH DETERMINA-  
 25 TION.—If the determination of an independent

1 medical reviewer is to reverse or modify the de-  
2 nial, the plan or issuer, upon the receipt of such  
3 determination, shall authorize coverage to com-  
4 ply with the medical reviewer's determination in  
5 accordance with the timeframe established by  
6 the medical reviewer.

7 (2) FAILURE TO COMPLY.—

8 (A) IN GENERAL.—If a plan or issuer fails  
9 to comply with the timeframe established under  
10 paragraph (1)(B) with respect to a participant,  
11 beneficiary, or enrollee, where such failure to  
12 comply is caused by the plan or issuer, the par-  
13 ticipant, beneficiary, or enrollee may obtain the  
14 items or services involved (in a manner con-  
15 sistent with the determination of the inde-  
16 pendent external reviewer) from any provider  
17 regardless of whether such provider is a partici-  
18 pating provider under the plan or coverage.

19 (B) REIMBURSEMENT.—

20 (i) IN GENERAL.—Where a partici-  
21 pant, beneficiary, or enrollee obtains items  
22 or services in accordance with subpara-  
23 graph (A), the plan or issuer involved shall  
24 provide for reimbursement of the costs of  
25 such items or services. Such reimburse-

1           ment shall be made to the treating health  
2           care professional or to the participant, ben-  
3           eficiary, or enrollee (in the case of a partic-  
4           ipant, beneficiary, or enrollee who pays for  
5           the costs of such items or services).

6           (ii) AMOUNT.—The plan or issuer  
7           shall fully reimburse a professional, partici-  
8           pant, beneficiary, or enrollee under clause  
9           (i) for the total costs of the items or serv-  
10          ices provided (regardless of any plan limi-  
11          tations that may apply to the coverage of  
12          such items or services) so long as the items  
13          or services were provided in a manner con-  
14          sistent with the determination of the inde-  
15          pendent medical reviewer.

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

1 fees) incurred in recovering such reimburse-  
 2 ment.

3 (D) AVAILABLE REMEDIES.—The remedies  
 4 provided under this paragraph are in addition  
 5 to any other available remedies.

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

9 (A) MONETARY PENALTIES.—

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

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 external reviewer,  
6 the Secretary shall assess a civil penalty of  
7 \$10,000 against the plan and the plan  
8 shall pay such penalty to the participant,  
9 beneficiary, or enrollee 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, beneficiary, or enrollee with respect  
14 to a group health plan, or a health insurance  
15 issuer offering health insurance coverage, in  
16 which a plaintiff alleges that a person referred  
17 to in such subparagraph has taken an action re-  
18 sulting in a refusal of a benefit determined by  
19 an external appeal entity to be covered, or has  
20 failed to take an action for which such person  
21 is responsible under the terms and conditions of  
22 the plan or coverage and which is necessary  
23 under the plan or coverage for authorizing a  
24 benefit, the court shall cause to be served on

1 the defendant an order requiring the defend-  
2 ant—

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 reasonable  
6 attorney's fee and other reasonable costs  
7 relating to the prosecution of the action on  
8 the charges on which the plaintiff prevails.

9 (C) ADDITIONAL CIVIL PENALTIES.—

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

19 (I) any pattern or practice of re-  
20 peated refusal to authorize a benefit  
21 determined by an external appeal enti-  
22 ty to be covered; or

23 (II) any pattern or practice of re-  
24 peated violations of the requirements



1 of this section with respect to such  
2 plan or coverage.

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

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

15 (II) \$500,000.

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

1 from returning to any such position or involve-  
 2 ment for a period determined by the court.

3 (4) PROTECTION OF LEGAL RIGHTS.—Nothing  
 4 in this subsection or subtitle shall be construed as  
 5 altering or eliminating any cause of action or legal  
 6 rights or remedies of participants, beneficiaries, en-  
 7 rollees, and others under State or Federal law (in-  
 8 cluding sections 502 and 503 of the Employee Re-  
 9 tirement Income Security Act of 1974), including  
 10 the right to file judicial actions to enforce rights.

11 (g) QUALIFICATIONS OF INDEPENDENT MEDICAL  
 12 REVIEWERS.—

13 (1) IN GENERAL.—In referring a denial to 1 or  
 14 more individuals to conduct independent medical re-  
 15 view under subsection (c), the qualified external re-  
 16 view entity shall ensure that—

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

20 (B) with respect to each review at least 1  
 21 such reviewer meets the requirements described  
 22 in paragraphs (4) and (5); and

23 (C) compensation provided by the entity to  
 24 the reviewer is consistent with paragraph (6).

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

5           (A) is appropriately credentialed or li-  
6       censed in 1 or more States to deliver health  
7       care services; and

8           (B) typically treats the condition, makes  
9       the diagnosis, or provides the type of treatment  
10      under review.

11       (3) INDEPENDENCE.—

12           (A) IN GENERAL.—Subject to subpara-  
13      graph (B), each independent medical reviewer  
14      in a case shall—

15           (i) not be a related party (as defined  
16      in paragraph (7));

17           (ii) not have a material familial, fi-  
18      nancial, or professional relationship with  
19      such a party; and

20           (iii) not otherwise have a conflict of  
21      interest with such a party (as determined  
22      under regulations).

23           (B) EXCEPTION.—Nothing in subpara-  
24      graph (A) shall be construed to—

1 (i) prohibit an individual, solely on the  
2 basis of affiliation with the plan or issuer,  
3 from serving as an independent medical re-  
4 viewer if—

5 (I) a non-affiliated individual is  
6 not reasonably available;

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

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

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

20 (ii) prohibit an individual who has  
21 staff privileges at the institution where the  
22 treatment involved takes place from serv-  
23 ing as an independent medical reviewer  
24 merely on the basis of such affiliation if  
25 the affiliation is disclosed to the plan or

1 issuer and the participant, beneficiary, or  
 2 enrollee (or authorized representative), and  
 3 neither party objects; or

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

8 (4) PRACTICING HEALTH CARE PROFESSIONAL  
 9 IN SAME FIELD.—

10 (A) IN GENERAL.—In a case involving  
 11 treatment, or the provision of items or serv-  
 12 ices—

13 (i) by a physician, a reviewer shall be  
 14 a practicing physician (allopathic or osteo-  
 15 pathic) of the same or similar specialty, as  
 16 a physician who, acting within the appro-  
 17 priate scope of practice within the State in  
 18 which the service is provided or rendered,  
 19 typically treats the condition, makes the  
 20 diagnosis, or provides the type of treat-  
 21 ment under review; or

22 (ii) by a non-physician health care  
 23 professional, a reviewer (or reviewers) shall  
 24 include at least one practicing non-physi-  
 25 cian health care professional of the same

1 or similar specialty as the non-physician  
2 health care professional who, acting within  
3 the appropriate scope of practice within  
4 the State in which the service is provided  
5 or rendered, typically treats the condition,  
6 makes the diagnosis, or provides the type  
7 of treatment under review.

8 (B) PRACTICING DEFINED.—For purposes  
9 of this paragraph, the term “practicing” means,  
10 with respect to an individual who is a physician  
11 or other health care professional that the indi-  
12 vidual provides health care services to individual  
13 patients on average at least 2 days per week.

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

17 (6) LIMITATIONS ON REVIEWER COMPENSA-  
18 TION.—Compensation provided by a qualified exter-  
19 nal review entity to an independent medical reviewer  
20 in connection with a review under this section  
21 shall—

22 (A) not exceed a reasonable level; and

23 (B) not be contingent on the decision ren-  
24 dered by the reviewer.

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

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

9           (B) The participant, beneficiary, or en-  
10 rollee (or authorized representative).

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

14           (D) The institution at which the items or  
15 services (or treatment) involved in the denial  
16 are provided.

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

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

23 (h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

24           (1) SELECTION OF QUALIFIED EXTERNAL RE-  
25 VIEW ENTITIES.—

(A) LIMITATION ON PLAN OR ISSUER SELECTION.—The appropriate Secretary shall implement procedures—

(i) to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner; and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

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

(B) STATE AUTHORITY WITH RESPECT TO QUALIFIED EXTERNAL REVIEW ENTITIES FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the



1 State in a manner determined by the State to  
 2 assure an unbiased determination.

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

10 (3) TERMS AND CONDITIONS OF CONTRACT.—  
 11 The terms and conditions of a contract under para-  
 12 graph (2) shall—

13 (A) be consistent with the standards the  
 14 appropriate Secretary shall establish to assure  
 15 there is no real or apparent conflict of interest  
 16 in the conduct of external review activities; and

17 (B) provide that the costs of the external  
 18 review process shall be borne by the plan or  
 19 issuer.

20 Subparagraph (B) shall not be construed as apply-  
 21 ing to the imposition of a filing fee under subsection  
 22 (b)(2)(A)(iv) or costs incurred by the participant,  
 23 beneficiary, or enrollee (or authorized representative)  
 24 or treating health care professional (if any) in sup-

port of the review, including the provision of additional evidence or information.

(4) QUALIFICATIONS.—

(A) IN GENERAL.—In this section, the term “qualified external review entity” means, in relation to a plan or issuer, an entity that is initially certified (and periodically recertified) under subparagraph (C) as meeting the following requirements:

(i) The entity has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to carry out duties of a qualified external review entity under this section on a timely basis, including making determinations under subsection (b)(2)(A) and providing for independent medical reviews under subsection (d).

(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or subsidiary of a professional or trade association of plans or issuers or of health care providers.

(iii) The entity has provided assurances that it will conduct external review

1 activities consistent with the applicable re-  
2 quirements of this section and standards  
3 specified in subparagraph (C), including  
4 that it will not conduct any external review  
5 activities in a case unless the independence  
6 requirements of subparagraph (B) are met  
7 with respect to the case.

8 (iv) The entity has provided assur-  
9 ances that it will provide information in a  
10 timely manner under subparagraph (D).

11 (v) The entity meets such other re-  
12 quirements as the appropriate Secretary  
13 provides by regulation.

14 (B) INDEPENDENCE REQUIREMENTS.—

15 (i) IN GENERAL.—Subject to clause  
16 (ii), an entity meets the independence re-  
17 quirements of this subparagraph with re-  
18 spect to any case if the entity—

19 (I) is not a related party (as de-  
20 fined in subsection (g)(7));

21 (II) does not have a material fa-  
22 milial, financial, or professional rela-  
23 tionship with such a party; and

1 (III) does not otherwise have a  
2 conflict of interest with such a party  
3 (as determined under regulations).

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

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

17 (I) not exceed a reasonable level;  
18 and

19 (II) not be contingent on any de-  
20 cision rendered by the entity or by  
21 any independent medical reviewer.

22 (C) CERTIFICATION AND RECERTIFICATION  
23 PROCESS.—

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

4 (I) under a process that is recog-  
5 nized or approved by the appropriate  
6 Secretary; or

7 (II) by a qualified private stand-  
8 ard-setting organization that is ap-  
9 proved by the appropriate Secretary  
10 under clause (iii).

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

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

24 (I) will carry out (and has car-  
25 ried out, in the case of recertification)

1 the responsibilities of such an entity  
2 in accordance with this section, in-  
3 cluding meeting applicable deadlines;

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

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

14 (IV) in the case of recertification,  
15 shall review the matters described in  
16 clause (iv).

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

1           recertification) of external review entities  
2           under clause (ii).

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

12                   (I) Provision of information  
13                  under subparagraph (D).

14                   (II) Adherence to applicable  
15                  deadlines (both by the entity and by  
16                  independent medical reviewers it re-  
17                  fers cases to).

18                   (III) Compliance with limitations  
19                  on compensation (with respect to both  
20                  the entity and independent medical re-  
21                  viewers it refers cases to).

22                   (IV) Compliance with applicable  
23                  independence requirements.

24                   (V) Compliance with the require-  
25                  ment of subsection (d)(1) that only

1 medically reviewable decisions shall be  
2 the subject of independent medical re-  
3 view and with the requirement of sub-  
4 section (d)(3) that independent med-  
5 ical reviewers may not require cov-  
6 erage for specifically excluded bene-  
7 fits.

8 (v) PERIOD OF CERTIFICATION OR RE-  
9 CERTIFICATION.—A certification or recer-  
10 tification provided under this paragraph  
11 shall extend for a period not to exceed 2  
12 years.

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



1 (vii) PETITION FOR DENIAL OR WITH-  
2 DRAWAL.—An individual may petition the  
3 Secretary, or an organization providing the  
4 certification involves, for a denial of recer-  
5 tification or a withdrawal of a certification  
6 with respect to an entity under this sub-  
7 paragraph if there is a pattern or practice  
8 of such entity failing to meet a require-  
9 ment of this section.

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

16 (D) PROVISION OF INFORMATION.—

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

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

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

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

16 (II) The disposition by the entity  
 17 of such denials, including the number  
 18 referred to a independent medical re-  
 19 viewer and the reasons for such dis-  
 20 positions (including the application of  
 21 exclusions), on a plan or issuer-spe-  
 22 cific basis and on a health care spe-  
 23 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 the  
5 information required to be submitted  
6 as a condition of certification with re-  
7 spect to the entity's performance of  
8 external review activities.

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

11 (I) IN GENERAL.—In the case of  
12 a qualified external review entity  
13 which is certified (or recertified)  
14 under this subsection by a qualified  
15 private standard-setting organization,  
16 at the request of the organization, the  
17 entity shall provide the organization  
18 with the information provided to the  
19 appropriate Secretary under clause  
20 (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.—Informa-  
4 tion provided under this subparagraph may  
5 be used by the appropriate Secretary and  
6 qualified private standard-setting organiza-  
7 tions to conduct oversight of qualified ex-  
8 ternal review entities, including recertifi-  
9 cation of such entities, and shall be made  
10 available to the public in an appropriate  
11 manner.

12 (E) LIMITATION ON LIABILITY.—No quali-  
13 fied external review entity having a contract  
14 with a plan or issuer, and no person who is em-  
15 ployed by any such entity or who furnishes pro-  
16 fessional services to such entity (including as an  
17 independent medical reviewer), shall be held by  
18 reason of the performance of any duty, func-  
19 tion, or activity required or authorized pursuant  
20 to this section, to be civilly liable under any law  
21 of the United States or of any State (or polit-  
22 ical subdivision thereof) if there was no actual  
23 malice or gross misconduct in the performance  
24 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           the General Accounting Office shall prepare and  
4           submit to the appropriate committees of Congress a  
5           report concerning—

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

8                   (B) the number of denials that have been  
9                   upheld by independent medical reviewers and  
10                  the number of denials that have been reversed  
11                  by such reviewers; and

12                  (C) the extent to which independent med-  
13                  ical reviewers are requiring coverage for bene-  
14                  fits that are specifically excluded under the plan  
15                  or coverage.

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

17           (a) GRANTS.—

18                   (1) IN GENERAL.—The Secretary of Health and  
19                  Human Services (referred to in this section as the  
20                  “Secretary”) shall establish a fund, to be known as  
21                  the “Health Care Consumer Assistance Fund”, to be  
22                  used to award grants to eligible States to carry out  
23                  consumer assistance activities (including programs  
24                  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 offered by a  
 3 health insurance issuer bears to the total num-  
 4 ber of individuals so covered in all States (as  
 5 determined by the Secretary). Any amounts  
 6 provided to a State under this subsection that  
 7 are not used by the State shall be remitted to  
 8 the Secretary and reallocated in accordance  
 9 with this subparagraph.

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

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

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

24 (A) IN GENERAL.—From amounts pro-  
 25 vided under a grant under this subsection, a



1 State shall, directly or through a contract with  
2 an independent, nonprofit entity with dem-  
3 onstrated experience in serving the needs of  
4 health care consumers, provide for the estab-  
5 lishment and operation of a State health care  
6 consumer assistance office.

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

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

20 (b) USE OF FUNDS.—

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

1 amount of such grant to ensure the adequate train-  
2 ing of personnel carrying out such activities. To re-  
3 ceive amounts under this subsection, an eligible enti-  
4 ty shall provide consumer assistance services, includ-  
5 ing—

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

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

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

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

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

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

1 nonlitigative settings to appeal the denial, ter-  
2 mination, or reduction of health care services,  
3 or the refusal to pay for such services, under a  
4 group health plan or health insurance coverage  
5 offered by a health insurance issuer.

6 (2) CONFIDENTIALITY AND ACCESS TO INFOR-  
7 MATION.—

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

14 (B) CONTRACT ENTITY.—With respect to a  
15 State that, through contract, establishes a  
16 health care consumer assistance office, such of-  
17 fice shall establish and implement procedures  
18 and protocols, consistent with applicable Fed-  
19 eral and State laws, to ensure the confiden-  
20 tiality of all information shared by a partici-  
21 pant, beneficiary, enrollee, or their personal  
22 representative and their health care providers,  
23 group health plans, or health insurance insurers  
24 with the office and to ensure that no such infor-  
25 mation is used by the office, or released or dis-

1 closed to State agencies or outside persons or  
2 entities without the prior written authorization  
3 (in accordance with section 164.508 of title 45,  
4 Code of Federal Regulations) of the individual  
5 or personal representative. The office may, con-  
6 sistent with applicable Federal and State con-  
7 fidentiality laws, collect, use or disclose aggre-  
8 gate information that is not individually identi-  
9 fiable (as defined in section 164.501 of title 45,  
10 Code of Federal Regulations). The office shall  
11 provide a written description of the policies and  
12 procedures of the office with respect to the  
13 manner in which health information may be  
14 used or disclosed to carry out consumer assist-  
15 ance activities. The office shall provide health  
16 care providers, group health plans, or health in-  
17 surance issuers with a written authorization (in  
18 accordance with section 164.508 of title 45,  
19 Code of Federal Regulations) to allow the office  
20 to obtain medical information relevant to the  
21 matter before the office.

22 (3) AVAILABILITY OF SERVICES.—The health  
23 care consumer assistance office of a State shall not  
24 discriminate in the provision of information, refer-  
25 rals, and services regardless of the source of the in-

dividual's health insurance coverage or prospective coverage, including individuals covered under a group health plan or health insurance coverage offered by a health insurance issuer, the medicare or medicaid programs under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 and 1396 et seq.), or under any other Federal or State health care program.

(4) DESIGNATION OF RESPONSIBILITIES.—

(A) WITHIN EXISTING STATE ENTITY.—If the health care consumer assistance office of a State is located within an existing State regulatory agency or office of an elected State official, the State shall ensure that—

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

(ii) the office establishes and implements procedures and protocols to ensure the confidentiality of all information shared by a participant, beneficiary, or enrollee or their personal representative and their health care providers, group health

1 plans, or health insurance issuers with the  
 2 office and to ensure that no information is  
 3 disclosed to the State agency or office  
 4 without the written authorization of the in-  
 5 dividual or their personal representative in  
 6 accordance with paragraph (2).

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

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

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

23 (c) REPORT.—Not later than 1 year after the Sec-  
 24 retary first awards grants under this section, and annually  
 25 thereafter, the Secretary shall prepare and submit to the

1 appropriate committees of Congress a report concerning  
 2 the activities funded under this section and the effective-  
 3 ness of such activities in resolving health care-related  
 4 problems and grievances.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
 6 are authorized to be appropriated such sums as may be  
 7 necessary to carry out this section.

## 8 **Subtitle B—Access to Care**

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

10 (a) IN GENERAL.—If—

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

21 (2) a group health plan offers to participants or  
 22 beneficiaries health benefits which provide for cov-  
 23 erage of services only if such services are furnished  
 24 through health care professionals and providers who  
 25 are members of a network of health care profes-

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

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

23        (c) OPEN SEASON.—An enrollee, participant, or ben-  
24 eficiary, may change to the offering provided under this  
25 section only during a time period determined by the health



1 insurance issuer or group health plan. Such time period  
2 shall occur at least annually.

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

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

12 (b) SPECIALISTS.—

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

21 (2) LIMITATION.—Paragraph (1) shall not  
22 apply to specialty care if the plan or issuer clearly  
23 informs participants, beneficiaries, and enrollees of  
24 the limitations on choice of participating health care  
25 professionals with respect to such care.

1           (3) CONSTRUCTION.—Nothing in this sub-  
 2           section shall be construed as affecting the applica-  
 3           tion of section 114 (relating to access to specialty  
 4           care).

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

6           (a) COVERAGE OF EMERGENCY SERVICES.—

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

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

15                   (B) whether the health care provider fur-  
 16                   nishing such services is a participating provider  
 17                   with respect to such services;

18                   (C) in a manner so that, if such services  
 19                   are provided to a participant, beneficiary, or en-  
 20                   rollee—

21                           (i) by a nonparticipating health care  
 22                           provider with or without prior authoriza-  
 23                           tion, or

24                           (ii) by a participating health care pro-  
 25                           vider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

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

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of

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

3 (B) EMERGENCY SERVICES.—The term  
4 “emergency services” means, with respect to an  
5 emergency medical condition—

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

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

19 (C) STABILIZE.—The term “to stabilize”,  
20 with respect to an emergency medical condition  
21 (as defined in subparagraph (A)), has the  
22 meaning given in section 1867(e)(3) of the So-  
23 cial Security Act (42 U.S.C. 1395dd(e)(3)).

24 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND  
25 POST-STABILIZATION CARE.—A group health plan, and

1 health insurance coverage offered by a health insurance  
 2 issuer, must provide reimbursement for maintenance care  
 3 and post-stabilization care in accordance with the require-  
 4 ments of section 1852(d)(2) of the Social Security Act (42  
 5 U.S.C. 1395w-22(d)(2)). Such reimbursement shall be  
 6 provided in a manner consistent with subsection (a)(1)(C).

7 (c) COVERAGE OF EMERGENCY AMBULANCE SERV-  
 8 ICES.—

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

19 (2) EMERGENCY AMBULANCE SERVICES.—For  
 20 purposes of this subsection, the term “emergency  
 21 ambulance services” means ambulance services (as  
 22 defined for purposes of section 1861(s)(7) of the So-  
 23 cial Security Act) furnished to transport an indi-  
 24 vidual who has an emergency medical condition (as  
 25 defined in subsection (a)(2)(A)) to a hospital for the

1 receipt of emergency services (as defined in sub-  
 2 section (a)(2)(B)) in a case in which the emergency  
 3 services are covered under the plan or coverage pur-  
 4 suant to subsection (a)(1) and a prudent layperson,  
 5 with an average knowledge of health and medicine,  
 6 could reasonably expect that the absence of such  
 7 transport would result in placing the health of the  
 8 individual in serious jeopardy, serious impairment of  
 9 bodily function, or serious dysfunction of any bodily  
 10 organ or part.

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

12 (a) TIMELY ACCESS.—

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

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

23 (A) to require the coverage under a group  
 24 health plan or health insurance coverage of ben-  
 25 efits or services;

(B) to prohibit a plan or issuer from including providers in the network only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees; or

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

(3) ACCESS TO CERTAIN PROVIDERS.—

(A) IN GENERAL.—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a nonparticipating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) REFERRALS.—

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

6                   (A) shall be for an appropriate duration of  
 7                   time or number of referrals, including an au-  
 8                   thorization for a standing referral where appro-  
 9                   priate; and

10                   (B) may not be refused solely because the  
 11                   authorization involves services of a nonpartici-  
 12                   pating specialist (described in subsection  
 13                   (a)(3)).

14           (2) REFERRALS FOR ONGOING SPECIAL CONDI-  
 15           TIONS.—

16                   (A) IN GENERAL.—Subject to subsection  
 17                   (a)(1), a group health plan and a health insur-  
 18                   ance issuer shall permit a participant, bene-  
 19                   ficiary, or enrollee who has an ongoing special  
 20                   condition (as defined in subparagraph (B)) to  
 21                   receive a referral to a specialist for the treat-  
 22                   ment of such condition and such specialist may  
 23                   authorize such referrals, procedures, tests, and  
 24                   other medical services with respect to such con-  
 25                   dition, or coordinate the care for such condi-



tion, subject to the terms of a treatment plan  
(if any) referred to in subsection (c) with re-  
spect to the condition.

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

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

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

(c) TREATMENT PLANS.—

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

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

(i) is developed by the specialist, in  
consultation with the case manager or pri-  
mary care provider, and the participant,  
beneficiary, or enrollee, and

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

1 (B) in accordance with applicable quality  
 2 assurance and utilization review standards of  
 3 the plan or issuer.

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

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

17 **SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECO-**  
 18 **LOGICAL CARE.**

19 (a) GENERAL RIGHTS.—

20 (1) DIRECT ACCESS.—A group health plan, and  
 21 a health insurance issuer offering health insurance  
 22 coverage, described in subsection (b) may not re-  
 23 quire authorization or referral by the plan, issuer, or  
 24 any person (including a primary care provider de-  
 25 scribed in subsection (b)(2)) in the case of a female

1 participant, beneficiary, or enrollee who seeks cov-  
 2 erage for obstetrical or gynecological care provided  
 3 by a participating health care professional who spe-  
 4 cializes in obstetrics or gynecology.

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

15 (b) APPLICATION OF SECTION.—A group health plan,  
 16 or health insurance issuer offering health insurance cov-  
 17 erage, described in this subsection is a group health plan  
 18 or coverage that—

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

21 (2) requires the designation by a participant,  
 22 beneficiary, or enrollee of a participating primary  
 23 care provider.

24 (c) CONSTRUCTION.—Nothing in subsection (a) shall  
 25 be construed to—

1           (1) waive any exclusions of coverage under the  
2           terms and conditions of the plan or health insurance  
3           coverage with respect to coverage of obstetrical or  
4           gynecological care; or

5           (2) preclude the group health plan or health in-  
6           surance issuer involved from requiring that the ob-  
7           stetrical or gynecological provider notify the primary  
8           care health care professional or the plan or issuer of  
9           treatment decisions.

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

11           (a) PEDIATRIC CARE.—In the case of a person who  
12           has a child who is a participant, beneficiary, or enrollee  
13           under a group health plan, or health insurance coverage  
14           offered by a health insurance issuer, if the plan or issuer  
15           requires or provides for the designation of a participating  
16           primary care provider for the child, the plan or issuer shall  
17           permit such person to designate a physician (allopathic or  
18           osteopathic) who specializes in pediatrics as the child's pri-  
19           mary care provider if such provider participates in the net-  
20           work of the plan or issuer.

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

1 **SEC. 117. CONTINUITY OF CARE.**

2 (a) **TERMINATION OF PROVIDER.—**

3 (1) **IN GENERAL.—**If—

4 (A) a contract between a group health  
5 plan, or a health insurance issuer offering  
6 health insurance coverage, and a treating health  
7 care provider is terminated (as defined in para-  
8 graph (e)(4)), or

9 (B) benefits or coverage provided by a  
10 health care provider are terminated because of  
11 a change in the terms of provider participation  
12 in such plan or coverage,  
13 the plan or issuer shall meet the requirements of  
14 paragraph (3) with respect to each continuing care  
15 patient.

16 (2) **TREATMENT OF TERMINATION OF CON-**  
17 **TRACT WITH HEALTH INSURANCE ISSUER.—**If a  
18 contract for the provision of health insurance cov-  
19 erage between a group health plan and a health in-  
20 surance issuer is terminated and, as a result of such  
21 termination, coverage of services of a health care  
22 provider is terminated with respect to an individual,  
23 the provisions of paragraph (1) (and the succeeding  
24 provisions of this section) shall apply under the plan  
25 in the same manner as if there had been a contract  
26 between the plan and the provider that had been ter-

1       minated, but only with respect to benefits that are  
 2       covered under the plan after the contract termi-  
 3       nation.

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

6               (A) notify the continuing care patient in-  
 7       volved, or arrange to have the patient notified  
 8       pursuant to subsection (d)(2), on a timely basis  
 9       of the termination described in paragraph (1)  
 10      (or paragraph (2), if applicable) and the right  
 11      to elect continued transitional care from the  
 12      provider under this section;

13              (B) provide the patient with an oppor-  
 14      tunity to notify the plan or issuer of the pa-  
 15      tient’s need for transitional care; and

16              (C) subject to subsection (c), permit the  
 17      patient to elect to continue to be covered with  
 18      respect to the course of treatment by such pro-  
 19      vider with the provider’s consent during a tran-  
 20      sitional period (as provided for under subsection  
 21      (b)).

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

1 (A) is undergoing a course of treatment  
 2 for a serious and complex condition from the  
 3 provider at the time the plan or issuer receives  
 4 or provides notice of provider, benefit, or cov-  
 5 erage termination described in paragraph (1)  
 6 (or paragraph (2), if applicable);

7 (B) is undergoing a course of institutional  
 8 or inpatient care from the provider at the time  
 9 of such notice;

10 (C) is scheduled to undergo non-elective  
 11 surgery from the provider at the time of such  
 12 notice;

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

16 (E) is or was determined to be terminally  
 17 ill (as determined under section 1861(dd)(3)(A)  
 18 of the Social Security Act) at the time of such  
 19 notice, but only with respect to a provider that  
 20 was treating the terminal illness before the date  
 21 of such notice.

22 (b) TRANSITIONAL PERIODS.—

23 (1) SERIOUS AND COMPLEX CONDITIONS.—The  
 24 transitional period under this subsection with re-  
 25 spect to a continuing care patient described in sub-

1 section (a)(4)(A) shall extend for up to 90 days (as  
 2 determined by the treating health care professional)  
 3 from the date of the notice described in subsection  
 4 (a)(3)(A).

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

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

12 (B) the date of discharge of the patient  
 13 from such care or the termination of the period  
 14 of institutionalization, or, if later, the date of  
 15 completion of reasonable follow-up care.

16 (3) SCHEDULED NON-ELECTIVE SURGERY.—  
 17 The transitional period under this subsection for a  
 18 continuing care patient described in subsection  
 19 (a)(4)(C) shall extend until the completion of the  
 20 surgery involved and post-surgical follow-up care re-  
 21 lating to the surgery and occurring within 90 days  
 22 after the date of the surgery.

23 (4) PREGNANCY.—The transitional period  
 24 under this subsection for a continuing care patient  
 25 described in subsection (a)(4)(D) shall extend



1 through the provision of post-partum care directly  
2 related to the delivery.

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

9 (c) PERMISSIBLE TERMS AND CONDITIONS.—A  
10 group health plan or health insurance issuer may condi-  
11 tion coverage of continued treatment by a provider under  
12 this section upon the provider agreeing to the following  
13 terms and conditions:

14 (1) The treating health care provider agrees to  
15 accept reimbursement from the plan or issuer and  
16 continuing care patient involved (with respect to  
17 cost-sharing) at the rates applicable prior to the  
18 start of the transitional period as payment in full  
19 (or, in the case described in subsection (a)(2), at the  
20 rates applicable under the replacement plan or cov-  
21 erage after the date of the termination of the con-  
22 tract with the group health plan or health insurance  
23 issuer) and not to impose cost-sharing with respect  
24 to the patient in an amount that would exceed the  
25 cost-sharing that could have been imposed if the

1 contract referred to in subsection (a)(1) had not  
2 been terminated.

3 (2) The treating health care provider agrees to  
4 adhere to the quality assurance standards of the  
5 plan or issuer responsible for payment under para-  
6 graph (1) and to provide to such plan or issuer nec-  
7 essary medical information related to the care pro-  
8 vided.

9 (3) The treating health care provider agrees  
10 otherwise to adhere to such plan's or issuer's policies  
11 and procedures, including procedures regarding re-  
12 ferrals and obtaining prior authorization and pro-  
13 viding services pursuant to a treatment plan (if any)  
14 approved by the plan or issuer.

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

17 (1) to require the coverage of benefits which  
18 would not have been covered if the provider involved  
19 remained a participating provider; or

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

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

1 (B) provide the plan or issuer with the  
2 name of each participant, beneficiary, or en-  
3 rollee who the provider believes is a continuing  
4 care patient.

5 (e) DEFINITIONS.—In this section:

6 (1) CONTRACT.—The term “contract” includes,  
7 with respect to a plan or issuer and a treating  
8 health care provider, a contract between such plan  
9 or issuer and an organized network of providers that  
10 includes the treating health care provider, and (in  
11 the case of such a contract) the contract between the  
12 treating health care provider and the organized net-  
13 work.

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

16 (A) any individual who is engaged in the  
17 delivery of health care services in a State and  
18 who is required by State law or regulation to be  
19 licensed or certified by the State to engage in  
20 the delivery of such services in the State; and

21 (B) any entity that is engaged in the deliv-  
22 ery of health care services in a State and that,  
23 if it is required by State law or regulation to be  
24 licensed or certified by the State to engage in

1           the delivery of such services in the State, is so  
2           licensed.

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

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

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

14           (4) TERMINATED.—The term “terminated” in-  
15           cludes, with respect to a contract, the expiration or  
16           nonrenewal of the contract, but does not include a  
17           termination of the contract for failure to meet appli-  
18           cable quality standards or for fraud.

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

20           (a) IN GENERAL.—To the extent that a group health  
21           plan, or health insurance coverage offered by a health in-  
22           surance issuer, provides coverage for benefits with respect  
23           to prescription drugs, and limits such coverage to drugs  
24           included in a formulary, the plan or issuer shall—

1           (1) ensure the participation of physicians and  
2           pharmacists in developing and reviewing such for-  
3           mulary;

4           (2) provide for disclosure of the formulary to  
5           providers; and

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

14          (b) COVERAGE OF APPROVED DRUGS AND MEDICAL  
15          DEVICES.—

16               (1) IN GENERAL.—A group health plan (and  
17               health insurance coverage offered in connection with  
18               such a plan) that provides any coverage of prescrip-  
19               tion drugs or medical devices shall not deny coverage  
20               of such a drug or device on the basis that the use  
21               is investigational, if the use—

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

23                               (i) is included in the labeling author-  
24                               ized by the application in effect for the  
25                               drug pursuant to subsection (b) or (j) of

1 section 505 of the Federal Food, Drug,  
2 and Cosmetic Act, without regard to any  
3 postmarketing requirements that may  
4 apply under such Act; or

5 (ii) is included in the labeling author-  
6 ized by the application in effect for the  
7 drug under section 351 of the Public  
8 Health Service Act, without regard to any  
9 postmarketing requirements that may  
10 apply pursuant to such section; or

11 (B) in the case of a medical device, is in-  
12 cluded in the labeling authorized by a regula-  
13 tion under subsection (d) or (3) of section 513  
14 of the Federal Food, Drug, and Cosmetic Act,  
15 an order under subsection (f) of such section, or  
16 an application approved under section 515 of  
17 such Act, without regard to any postmarketing  
18 requirements that may apply under such Act.

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

1 **SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**  
2 **APPROVED CLINICAL TRIALS.**

3 (a) COVERAGE.—

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

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

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

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

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

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

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

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

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

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

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

22 (2) Either—

23 (A) the referring physician is a partici-  
24 pating health care professional and has con-  
25 cluded that the individual’s participation in



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

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

10 (c) PAYMENT.—

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

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

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

23 (B) a nonparticipating provider, the pay-  
24 ment rate shall be at the rate the plan or issuer

1           would normally pay for comparable services  
2           under subparagraph (A).

3       (d) APPROVED CLINICAL TRIAL DEFINED.—

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

7           (A) approved and funded (which may in-  
8       clude funding through in-kind contributions) by  
9       one or more of the following:

10           (i) the National Institutes of Health;

11           (ii) a cooperative group or center of  
12       the National Institutes of Health, includ-  
13       ing a qualified nongovernmental research  
14       entity to which the National Cancer Insti-  
15       tute has awarded a center support grant;

16           (iii) either of the following if the con-  
17       ditions described in paragraph (2) are  
18       met—

19           (I) the Department of Veterans  
20       Affairs;

21           (II) the Department of Defense;

22           or

23           (B) approved by the Food and Drug Ad-  
24       ministration.

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

7                   (A) to be comparable to the system of peer  
 8                   review of studies and investigations used by the  
 9                   National Institutes of Health; and

10                   (B) assures unbiased review of the highest  
 11                   ethical standards by qualified individuals who  
 12                   have no interest in the outcome of the review.

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

16 **SEC. 120. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 17 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
 18 **DISSECTIONS FOR THE TREATMENT OF**  
 19 **BREAST CANCER AND COVERAGE FOR SEC-**  
 20 **ONDARY CONSULTATIONS.**

21           (a) INPATIENT CARE.—

22                   (1) IN GENERAL.—A group health plan, and a  
 23                   health insurance issuer providing health insurance  
 24                   coverage, that provides medical and surgical benefits  
 25                   shall ensure that inpatient coverage with respect to

1 the treatment of breast cancer is provided for a pe-  
 2 riod of time as is determined by the attending physi-  
 3 cian, in consultation with the patient, to be medi-  
 4 cally necessary and appropriate following—

5 (A) a mastectomy;

6 (B) a lumpectomy; or

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

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

14 (b) PROHIBITION ON CERTAIN MODIFICATIONS.—In  
 15 implementing the requirements of this section, a group  
 16 health plan, and a health insurance issuer providing health  
 17 insurance coverage, may not modify the terms and condi-  
 18 tions of coverage based on the determination by a partici-  
 19 pant, beneficiary, or enrollee to request less than the min-  
 20 imum coverage required under subsection (a).

21 (c) SECONDARY CONSULTATIONS.—

22 (1) IN GENERAL.—A group health plan, and a  
 23 health insurance issuer providing health insurance  
 24 coverage, that provides coverage with respect to  
 25 medical and surgical services provided in relation to

1 the diagnosis and treatment of cancer shall ensure  
2 that full coverage is provided for secondary consulta-  
3 tions by specialists in the appropriate medical fields  
4 (including pathology, radiology, and oncology) to  
5 confirm or refute such diagnosis. Such plan or issuer  
6 shall ensure that full coverage is provided for such  
7 secondary consultation whether such consultation is  
8 based on a positive or negative initial diagnosis. In  
9 any case in which the attending physician certifies in  
10 writing that services necessary for such a secondary  
11 consultation are not sufficiently available from spe-  
12 cialists operating under the plan or coverage with re-  
13 spect to whose services coverage is otherwise pro-  
14 vided under such plan or by such issuer, such plan  
15 or issuer shall ensure that coverage is provided with  
16 respect to the services necessary for the secondary  
17 consultation with any other specialist selected by the  
18 attending physician for such purpose at no addi-  
19 tional cost to the individual beyond that which the  
20 individual would have paid if the specialist was par-  
21 ticipating in the network of the plan or issuer.

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

1 (d) PROHIBITION ON PENALTIES OR INCENTIVES.—

2 A group health plan, and a health insurance issuer pro-  
3 viding health insurance coverage, may not—

4 (1) penalize or otherwise reduce or limit the re-  
5 imbursement of a provider or specialist because the  
6 provider or specialist provided care to a participant,  
7 beneficiary, or enrollee in accordance with this sec-  
8 tion;

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

16 (3) provide financial or other incentives to a  
17 physician or specialist to induce the physician or  
18 specialist to refrain from referring a participant,  
19 beneficiary, or enrollee for a secondary consultation  
20 that would otherwise be covered by the plan or cov-  
21 erage involved under subsection (c).

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

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

24 (a) REQUIREMENT.—

25 (1) DISCLOSURE.—

1 (A) IN GENERAL.—A group health plan,  
2 and a health insurance issuer that provides cov-  
3 erage in connection with health insurance cov-  
4 erage, shall provide for the disclosure to partici-  
5 pants, beneficiaries, and enrollees—

6 (i) of the information described in  
7 subsection (b) at the time of the initial en-  
8 rollment of the participant, beneficiary, or  
9 enrollee under the plan or coverage;

10 (ii) of such information on an annual  
11 basis—

12 (I) in conjunction with the elec-  
13 tion period of the plan or coverage if  
14 the plan or coverage has such an elec-  
15 tion period; or

16 (II) in the case of a plan or cov-  
17 erage that does not have an election  
18 period, in conjunction with the begin-  
19 ning of the plan or coverage year; and

20 (iii) of information relating to any  
21 material reduction to the benefits or infor-  
22 mation described in such subsection or  
23 subsection (c), in the form of a notice pro-  
24 vided not later than 30 days before the  
25 date on which the reduction takes effect.

1 (B) PARTICIPANTS, BENEFICIARIES, AND  
2 ENROLLEES.—The disclosure required under  
3 subparagraph (A) shall be provided—

4 (i) jointly to each participant, bene-  
5 ficiary, and enrollee who reside at the same  
6 address; or

7 (ii) in the case of a beneficiary or en-  
8 rollee who does not reside at the same ad-  
9 dress as the participant or another en-  
10 rollee, separately to the participant or  
11 other enrollees and such beneficiary or en-  
12 rollee.

13 (2) PROVISION OF INFORMATION.—Information  
14 shall be provided to participants, beneficiaries, and  
15 enrollees under this section at the last known ad-  
16 dress maintained by the plan or issuer with respect  
17 to such participants, beneficiaries, or enrollees, to  
18 the extent that such information is provided to par-  
19 ticipants, beneficiaries, or enrollees via the United  
20 States Postal Service or other private delivery serv-  
21 ice.

22 (b) REQUIRED INFORMATION.—The informational  
23 materials to be distributed under this section shall include  
24 for each option available under the group health plan or  
25 health insurance coverage the following:



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

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

4 (B) specific preventive services covered  
5 under the plan or coverage if such services are  
6 covered;

7 (C) any specific exclusions or express limi-  
8 tations of benefits described in section  
9 104(d)(3)(C);

10 (D) any other benefit limitations, including  
11 any annual or lifetime benefit limits and any  
12 monetary limits or limits on the number of vis-  
13 its, days, or services, and any specific coverage  
14 exclusions; and

15 (E) any definition of medical necessity  
16 used in making coverage determinations by the  
17 plan, issuer, or claims administrator.

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

20 (A) any premiums, deductibles, coinsur-  
21 ance, copayment amounts, and liability for bal-  
22 ance billing, for which the participant, bene-  
23 ficiary, or enrollee will be responsible under  
24 each option available under the plan;

1 (B) any maximum out-of-pocket expense  
2 for which the participant, beneficiary, or en-  
3 rollee may be liable;

4 (C) any cost-sharing requirements for out-  
5 of-network benefits or services received from  
6 nonparticipating providers; and

7 (D) any additional cost-sharing or charges  
8 for benefits and services that are furnished  
9 without meeting applicable plan or coverage re-  
10 quirements, such as prior authorization or  
11 precertification.

12 (3) DISENROLLMENT.—Information relating to  
13 the disenrollment of a participant, beneficiary, or en-  
14 rollee.

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

18 (5) PARTICIPATING PROVIDERS.—A directory of  
19 participating providers (to the extent a plan or  
20 issuer provides coverage through a network of pro-  
21 viders) that includes, at a minimum, the name, ad-  
22 dress, and telephone number of each participating  
23 provider, and information about how to inquire  
24 whether a participating provider is currently accept-  
25 ing new patients.

1           (6) CHOICE OF PRIMARY CARE PROVIDER.—A  
2       description of any requirements and procedures to  
3       be used by participants, beneficiaries, and enrollees  
4       in selecting, accessing, or changing their primary  
5       care provider, including providers both within and  
6       outside of the network (if the plan or issuer permits  
7       out-of-network services), and the right to select a pe-  
8       diatrician as a primary care provider under section  
9       116 for a participant, beneficiary, or enrollee who is  
10      a child if such section applies.

11          (7) PREAUTHORIZATION REQUIREMENTS.—A  
12      description of the requirements and procedures to be  
13      used to obtain preauthorization for health services,  
14      if such preauthorization is required.

15          (8) EXPERIMENTAL AND INVESTIGATIONAL  
16      TREATMENTS.—A description of the process for de-  
17      termining whether a particular item, service, or  
18      treatment is considered experimental or investiga-  
19      tional, and the circumstances under which such  
20      treatments are covered by the plan or issuer.

21          (9) SPECIALTY CARE.—A description of the re-  
22      quirements and procedures to be used by partici-  
23      pants, beneficiaries, and enrollees in accessing spe-  
24      cialty care and obtaining referrals to participating  
25      and nonparticipating specialists, including any limi-

1 tations on choice of health care professionals re-  
2 ferred to in section 112(b)(2) and the right to timely  
3 access to specialists care under section 114 if such  
4 section applies.

5 (10) CLINICAL TRIALS.—A description of the  
6 circumstances and conditions under which participa-  
7 tion in clinical trials is covered under the terms and  
8 conditions of the plan or coverage, and the right to  
9 obtain coverage for approved clinical trials under  
10 section 119 if such section applies.

11 (11) PRESCRIPTION DRUGS.—To the extent the  
12 plan or issuer provides coverage for prescription  
13 drugs, a statement of whether such coverage is lim-  
14 ited to drugs included in a formulary, a description  
15 of any provisions and cost-sharing required for ob-  
16 taining on- and off-formulary medications, and a de-  
17 scription of the rights of participants, beneficiaries,  
18 and enrollees in obtaining access to access to pre-  
19 scription drugs under section 118 if such section ap-  
20 plies.

21 (12) EMERGENCY SERVICES.—A summary of  
22 the rules and procedures for accessing emergency  
23 services, including the right of a participant, bene-  
24 ficiary, or enrollee to obtain emergency services  
25 under the prudent layperson standard under section

1 113, if such section applies, and any educational in-  
 2 formation that the plan or issuer may provide re-  
 3 garding the appropriate use of emergency services.

4 (13) CLAIMS AND APPEALS.—A description of  
 5 the plan or issuer’s rules and procedures pertaining  
 6 to claims and appeals, a description of the rights  
 7 (including deadlines for exercising rights) of partici-  
 8 pants, beneficiaries, and enrollees under subtitle A  
 9 in obtaining covered benefits, filing a claim for bene-  
 10 fits, and appealing coverage decisions internally and  
 11 externally (including telephone numbers and mailing  
 12 addresses of the appropriate authority), and a de-  
 13 scription of any additional legal rights and remedies  
 14 available under section 502 of the Employee Retirement  
 15 Income Security Act of 1974 and applicable  
 16 State law.

17 (14) ADVANCE DIRECTIVES AND ORGAN DONA-  
 18 TION.—A description of procedures for advance di-  
 19 rectives and organ donation decisions if the plan or  
 20 issuer maintains such procedures.

21 (15) INFORMATION ON PLANS AND ISSUERS.—  
 22 The name, mailing address, and telephone number  
 23 or numbers of the plan administrator and the issuer  
 24 to be used by participants, beneficiaries, and enroll-  
 25 ees seeking information about plan or coverage bene-

1 fits and services, payment of a claim, or authoriza-  
2 tion for services and treatment. Notice of whether  
3 the benefits under the plan or coverage are provided  
4 under a contract or policy of insurance issued by an  
5 issuer, or whether benefits are provided directly by  
6 the plan sponsor who bears the insurance risk.

7 (16) TRANSLATION SERVICES.—A summary de-  
8 scription of any translation or interpretation services  
9 (including the availability of printed information in  
10 languages other than English, audio tapes, or infor-  
11 mation in Braille) that are available for non-English  
12 speakers and participants, beneficiaries, and enroll-  
13 ees with communication disabilities and a description  
14 of how to access these items or services.

15 (17) ACCREDITATION INFORMATION.—Any in-  
16 formation that is made public by accrediting organi-  
17 zations in the process of accreditation if the plan or  
18 issuer is accredited, or any additional quality indica-  
19 tors (such as the results of enrollee satisfaction sur-  
20 veys) that the plan or issuer makes public or makes  
21 available to participants, beneficiaries, and enrollees.

22 (18) NOTICE OF REQUIREMENTS.—A descrip-  
23 tion of any rights of participants, beneficiaries, and  
24 enrollees that are established by the Patients' Bill of  
25 Rights Act of 2005 (excluding those described in

1 paragraphs (1) through (17)) if such sections apply.

2 The description required under this paragraph may  
 3 be combined with the notices of the type described  
 4 in sections 711(d), 713(b), or 606(a)(1) of the Em-  
 5 ployee Retirement Income Security Act of 1974 and  
 6 with any other notice provision that the appropriate  
 7 Secretary determines may be combined, so long as  
 8 such combination does not result in any reduction in  
 9 the information that would otherwise be provided to  
 10 the recipient.

11 (19) AVAILABILITY OF ADDITIONAL INFORMA-  
 12 TION.—A statement that the information described  
 13 in subsection (c), and instructions on obtaining such  
 14 information (including telephone numbers and, if  
 15 available, Internet websites), shall be made available  
 16 upon request.

17 (20) DESIGNATED DECISIONMAKERS.—A de-  
 18 scription of the participants and beneficiaries with  
 19 respect to whom each designated decisionmaker  
 20 under the plan has assumed liability under section  
 21 502(o) of the Employee Retirement Income Security  
 22 Act of 1974 and the name and address of each such  
 23 decisionmaker.

24 (c) ADDITIONAL INFORMATION.—The informational  
 25 materials to be provided upon the request of a participant,

1 beneficiary, or enrollee shall include for each option avail-  
2 able under a group health plan or health insurance cov-  
3 erage the following:

4           (1) STATUS OF PROVIDERS.—The State licen-  
5 sure status of the plan or issuer’s participating  
6 health care professionals and participating health  
7 care facilities, and, if available, the education, train-  
8 ing, specialty qualifications or certifications of such  
9 professionals.

10           (2) COMPENSATION METHODS.—A summary  
11 description by category of the applicable methods  
12 (such as capitation, fee-for-service, salary, bundled  
13 payments, per diem, or a combination thereof) used  
14 for compensating prospective or treating health care  
15 professionals (including primary care providers and  
16 specialists) and facilities in connection with the pro-  
17 vision of health care under the plan or coverage.

18           (3) PRESCRIPTION DRUGS.—Information about  
19 whether a specific prescription medication is in-  
20 cluded in the formulary of the plan or issuer, if the  
21 plan or issuer uses a defined formulary.

22           (4) UTILIZATION REVIEW ACTIVITIES.—A de-  
23 scription of procedures used and requirements (in-  
24 cluding circumstances, timeframes, and appeals  
25 rights) under any utilization review program under



1 sections 101 and 102, including any drug formulary  
2 program under section 118.

3 (5) EXTERNAL APPEALS INFORMATION.—Ag-  
4 gregate information on the number and outcomes of  
5 external medical reviews, relative to the sample size  
6 (such as the number of covered lives) under the plan  
7 or under the coverage of the issuer.

8 (d) MANNER OF DISCLOSURE.—The information de-  
9 scribed in this section shall be disclosed in an accessible  
10 medium and format that is calculated to be understood  
11 by a participant or enrollee.

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

16 (1) distributing any other additional informa-  
17 tion determined by the plan or issuer to be impor-  
18 tant or necessary in assisting participants, bene-  
19 ficiaries, and enrollees in the selection of a health  
20 plan or health insurance coverage; and

21 (2) complying with the provisions of this section  
22 by providing information in brochures, through the  
23 Internet or other electronic media, or through other  
24 similar means, so long as—

1 (A) the disclosure of such information in  
2 such form is in accordance with requirements  
3 as the appropriate Secretary may impose, and

4 (B) in connection with any such disclosure  
5 of information through the Internet or other  
6 electronic media—

7 (i) the recipient has affirmatively con-  
8 sented to the disclosure of such informa-  
9 tion in such form,

10 (ii) the recipient is capable of access-  
11 ing the information so disclosed on the re-  
12 cipient's individual workstation or at the  
13 recipient's home,

14 (iii) the recipient retains an ongoing  
15 right to receive paper disclosure of such in-  
16 formation and receives, in advance of any  
17 attempt at disclosure of such information  
18 to him or her through the Internet or  
19 other electronic media, notice in printed  
20 form of such ongoing right and of the  
21 proper software required to view informa-  
22 tion so disclosed, and

23 (iv) the plan administrator appro-  
24 priately ensures that the intended recipient  
25 is receiving the information so disclosed

1 and provides the information in printed  
2 form if the information is not received.

3 **Subtitle D—Protecting the Doctor-**  
4 **patient Relationship**

5 **SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN**  
6 **MEDICAL COMMUNICATIONS.**

7 (a) GENERAL RULE.—The provisions of any contract  
8 or agreement, or the operation of any contract or agree-  
9 ment, between a group health plan or health insurance  
10 issuer in relation to health insurance coverage (including  
11 any partnership, association, or other organization that  
12 enters into or administers such a contract or agreement)  
13 and a health care provider (or group of health care pro-  
14 viders) shall not prohibit or otherwise restrict a health  
15 care professional from advising such a participant, bene-  
16 ficiary, or enrollee who is a patient of the professional  
17 about the health status of the individual or medical care  
18 or treatment for the individual's condition or disease, re-  
19 gardless of whether benefits for such care or treatment  
20 are provided under the plan or coverage, if the professional  
21 is acting within the lawful scope of practice.

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

1 **SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PRO-**  
2 **VIDERS BASED ON LICENSURE.**

3 (a) IN GENERAL.—A group health plan, and a health  
4 insurance issuer with respect to health insurance coverage,  
5 shall not discriminate with respect to participation or in-  
6 demnification as to any provider who is acting within the  
7 scope of the provider’s license or certification under appli-  
8 cable State law, solely on the basis of such license or cer-  
9 tification.

10 (b) CONSTRUCTION.—Subsection (a) shall not be con-  
11 strued—

12 (1) as requiring the coverage under a group  
13 health plan or health insurance coverage of a par-  
14 ticular benefit or service or to prohibit a plan or  
15 issuer from including providers only to the extent  
16 necessary to meet the needs of the plan’s or issuer’s  
17 participants, beneficiaries, or enrollees or from es-  
18 tablishing any measure designed to maintain quality  
19 and control costs consistent with the responsibilities  
20 of the plan or issuer;

21 (2) to override any State licensure or scope-of-  
22 practice law; or

23 (3) as requiring a plan or issuer that offers net-  
24 work coverage to include for participation every will-  
25 ing provider who meets the terms and conditions of  
26 the plan or issuer.

1 **SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE**  
2 **ARRANGEMENTS.**

3 (a) IN GENERAL.—A group health plan and a health  
4 insurance issuer offering health insurance coverage may  
5 not operate any physician incentive plan (as defined in  
6 subparagraph (B) of section 1852(j)(4) of the Social Secu-  
7 rity Act) unless the requirements described in clauses (i),  
8 (ii)(I), and (iii) of subparagraph (A) of such section are  
9 met with respect to such a plan.

10 (b) APPLICATION.—For purposes of carrying out  
11 paragraph (1), any reference in section 1852(j)(4) of the  
12 Social Security Act to the Secretary, a MedicareAdvantage  
13 organization, or an individual enrolled with the organiza-  
14 tion shall be treated as a reference to the applicable au-  
15 thority, a group health plan or health insurance issuer,  
16 respectively, and a participant, beneficiary, or enrollee  
17 with the plan or organization, respectively.

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

21 **SEC. 134. PAYMENT OF CLAIMS.**

22 A group health plan, and a health insurance issuer  
23 offering health insurance coverage, shall provide for  
24 prompt payment of claims submitted for health care serv-  
25 ices or supplies furnished to a participant, beneficiary, or  
26 enrollee with respect to benefits covered by the plan or

1 issuer, in a manner that is no less protective than the pro-  
 2 visions of section 1842(c)(2) of the Social Security Act  
 3 (42 U.S.C. 1395u(c)(2)).

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

5 (a) PROTECTION FOR USE OF UTILIZATION REVIEW  
 6 AND GRIEVANCE PROCESS.—A group health plan, and a  
 7 health insurance issuer with respect to the provision of  
 8 health insurance coverage, may not retaliate against a par-  
 9 ticipant, beneficiary, enrollee, or health care provider  
 10 based on the participant's, beneficiary's, enrollee's or pro-  
 11 vider's use of, or participation in, a utilization review proc-  
 12 ess or a grievance process of the plan or issuer (including  
 13 an internal or external review or appeal process) under  
 14 this title.

15 (b) PROTECTION FOR QUALITY ADVOCACY BY  
 16 HEALTH CARE PROFESSIONALS.—

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

21 (A) discloses information relating to the  
 22 care, services, or conditions affecting one or  
 23 more participants, beneficiaries, or enrollees of  
 24 the plan or issuer to an appropriate public reg-  
 25 ulatory agency, an appropriate private accredi-

1           tation body, or appropriate management per-  
2           sonnel of the plan or issuer; or

3           (B) initiates, cooperates, or otherwise par-  
4           ticipates in an investigation or proceeding by  
5           such an agency with respect to such care, serv-  
6           ices, or conditions.

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

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

1 (A) the disclosure is made on the basis of  
 2 personal knowledge and is consistent with that  
 3 degree of learning and skill ordinarily possessed  
 4 by health care professionals with the same li-  
 5 censure or certification and the same experi-  
 6 ence;

7 (B) the professional reasonably believes the  
 8 information to be true;

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

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

21 (3) EXCEPTION AND SPECIAL RULE.—

22 (A) GENERAL EXCEPTION.—Paragraph (1)  
 23 does not protect disclosures that would violate  
 24 Federal or State law or diminish or impair the  
 25 rights of any person to the continued protection



1 of confidentiality of communications provided  
2 by such law.

3 (B) NOTICE OF INTERNAL PROCEDURES.—

4 Subparagraph (D) of paragraph (2) shall not  
5 apply unless the internal procedures involved  
6 are reasonably expected to be known to the  
7 health care professional involved. For purposes  
8 of this subparagraph, a health care professional  
9 is reasonably expected to know of internal pro-  
10 cedures if those procedures have been made  
11 available to the professional through distribu-  
12 tion or posting.

13 (C) INTERNAL PROCEDURE EXCEPTION.—

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

16 (i) the disclosure relates to an immi-  
17 nent hazard of loss of life or serious injury  
18 to a patient;

19 (ii) the disclosure is made to an ap-  
20 propriate private accreditation body pursu-  
21 ant to disclosure procedures established by  
22 the body; or

23 (iii) the disclosure is in response to an  
24 inquiry made in an investigation or pro-  
25 ceeding of an appropriate public regulatory

1           agency and the information disclosed is  
2           limited to the scope of the investigation or  
3           proceeding.

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

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

19          (6) CONSTRUCTIONS.—

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

1 (B) ENFORCEMENT OF PEER REVIEW PRO-  
 2 TOCOLS AND INTERNAL PROCEDURES.—Noth-  
 3 ing in this subsection shall be construed to pro-  
 4 hibit a plan, issuer, or provider from estab-  
 5 lishing and enforcing reasonable peer review or  
 6 utilization review protocols or determining  
 7 whether a protected health care professional has  
 8 complied with those protocols or from estab-  
 9 lishing and enforcing internal procedures for  
 10 the purpose of addressing quality concerns.

11 (C) RELATION TO OTHER RIGHTS.—Noth-  
 12 ing in this subsection shall be construed to  
 13 abridge rights of participants, beneficiaries, en-  
 14 rollees, and protected health care professionals  
 15 under other applicable Federal or State laws.

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

21 (A) with respect to a group health plan or  
 22 health insurance issuer, is an employee of the  
 23 plan or issuer or has a contract with the plan  
 24 or issuer for provision of services for which ben-  
 25 efits 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 provider respecting the provision of health care services.

## **Subtitle E—Definitions**

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

#### **(a) INCORPORATION OF GENERAL DEFINITIONS.—**

Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

#### **(b) SECRETARY.—**Except as otherwise provided, the

term “Secretary” means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term “appropriate Secretary” means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 714 of the Employee Retirement Income Security Act of 1974.

#### **(c) ADDITIONAL DEFINITIONS.—**For purposes of this

title:

##### **(1) APPLICABLE AUTHORITY.—**The term “ap-

plicable authority” means—

1 (A) in the case of a group health plan, the  
 2 Secretary of Health and Human Services and  
 3 the Secretary of Labor; and

4 (B) in the case of a health insurance issuer  
 5 with respect to a specific provision of this title,  
 6 the applicable State authority (as defined in  
 7 section 2791(d) of the Public Health Service  
 8 Act), or the Secretary of Health and Human  
 9 Services, if such Secretary is enforcing such  
 10 provision under section 2722(a)(2) or  
 11 2761(a)(2) of the Public Health Service Act.

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

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

24 (4) HEALTH CARE PROFESSIONAL.—The term  
 25 “health care professional” means an individual who

1 is licensed, accredited, or certified under State law  
2 to provide specified health care services and who is  
3 operating within the scope of such licensure, accredi-  
4 tation, or certification.

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

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

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

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

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

14          (10) TERMS AND CONDITIONS.—The term  
 15      “terms and conditions” includes, with respect to a  
 16      group health plan or health insurance coverage, re-  
 17      quirements imposed under this title with respect to  
 18      the plan or coverage.

19 **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**  
 20 **TION.**

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

23          (1) IN GENERAL.—Subject to paragraph (2),  
 24      this title shall not be construed to supersede any  
 25      provision of State law which establishes, implements,

1 or continues in effect any standard or requirement  
2 solely relating to health insurance issuers (in connec-  
3 tion with group health insurance coverage or other-  
4 wise) except to the extent that such standard or re-  
5 quirement prevents the application of a requirement  
6 of this title.

7 (2) CONTINUED PREEMPTION WITH RESPECT  
8 TO GROUP HEALTH PLANS.—Nothing in this title  
9 shall be construed to affect or modify the provisions  
10 of section 514 of the Employee Retirement Income  
11 Security Act of 1974 with respect to group health  
12 plans.

13 (3) CONSTRUCTION.—In applying this section,  
14 a State law that provides for equal access to, and  
15 availability of, all categories of licensed health care  
16 providers and services shall not be treated as pre-  
17 venting the application of any requirement of this  
18 title.

19 (b) APPLICATION OF SUBSTANTIALLY COMPLIANT  
20 STATE LAWS.—

21 (1) IN GENERAL.—In the case of a State law  
22 that imposes, with respect to health insurance cov-  
23 erage offered by a health insurance issuer and with  
24 respect to a group health plan that is a non-Federal  
25 governmental plan, a requirement that substantially



1 complies (within the meaning of subsection (c)) with  
 2 a patient protection requirement (as defined in para-  
 3 graph (3)) and does not prevent the application of  
 4 other requirements under this Act (except in the  
 5 case of other substantially compliant requirements),  
 6 in applying the requirements of this title under sec-  
 7 tion 2707 and 2753 (as applicable) of the Public  
 8 Health Service Act (as added by title II), subject to  
 9 subsection (a)(2)—

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

12 (B) the State law shall apply instead of the  
 13 patient protection requirement otherwise appli-  
 14 cable with respect to health insurance coverage  
 15 and non-Federal governmental plans.

16 (2) LIMITATION.—In the case of a group health  
 17 plan covered under title I of the Employee Retire-  
 18 ment Income Security Act of 1974, paragraph (1)  
 19 shall be construed to apply only with respect to the  
 20 health insurance coverage (if any) offered in connec-  
 21 tion with the plan.

22 (3) DEFINITIONS.—In this section:

23 (A) PATIENT PROTECTION REQUIRE-  
 24 MENT.—The term “patient protection require-  
 25 ment” means a requirement under this title,

and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this title.

(B) SUBSTANTIALLY COMPLIANT.—The terms “substantially compliant”, “substantially complies”, or “substantial compliance” with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(c) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies

1 with the patient protection requirement (or re-  
2 quirements) to which the law relates.

3 (B) APPROVAL DEADLINES.—

4 (i) INITIAL REVIEW.—Such a certifi-  
5 cation is considered approved unless the  
6 Secretary notifies the State in writing,  
7 within 90 days after the date of receipt of  
8 the certification, that the certification is  
9 disapproved (and the reasons for dis-  
10 approval) or that specified additional infor-  
11 mation is needed to make the determina-  
12 tion described in subparagraph (A).

13 (ii) ADDITIONAL INFORMATION.—

14 With respect to a State that has been noti-  
15 fied by the Secretary under clause (i) that  
16 specified additional information is needed  
17 to make the determination described in  
18 subparagraph (A), the Secretary shall  
19 make the determination within 60 days  
20 after the date on which such specified ad-  
21 ditional information is received by the Sec-  
22 retary.

23 (3) APPROVAL.—

1 (A) IN GENERAL.—The Secretary shall ap-  
2 prove a certification under paragraph (1) un-  
3 less—

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

8 (ii) the Secretary determines that the  
9 State law involved does not provide for pa-  
10 tient protections that substantially comply  
11 with the patient protection requirement (or  
12 requirements) to which the law relates.

13 (B) STATE CHALLENGE.—A State that has  
14 a certification disapproved by the Secretary  
15 under subparagraph (A) may challenge such  
16 disapproval in the appropriate United States  
17 district court.

18 (C) DEFERENCE TO STATES.—With re-  
19 spect to a certification submitted under para-  
20 graph (1), the Secretary shall give deference to  
21 the State’s interpretation of the State law in-  
22 volved with respect to the patient protection in-  
23 volved.

24 (D) PUBLIC NOTIFICATION.—The Sec-  
25 retary shall—

1 (i) provide a State with a notice of the  
2 determination to approve or disapprove a  
3 certification under this paragraph;

4 (ii) promptly publish in the Federal  
5 Register a notice that a State has sub-  
6 mitted a certification under paragraph (1);

7 (iii) promptly publish in the Federal  
8 Register the notice described in clause (i)  
9 with respect to the State; and

10 (iv) annually publish the status of all  
11 States with respect to certifications.

12 (4) CONSTRUCTION.—Nothing in this sub-  
13 section shall be construed as preventing the certifi-  
14 cation (and approval of certification) of a State law  
15 under this subsection solely because it provides for  
16 greater protections for patients than those protec-  
17 tions otherwise required to establish substantial  
18 compliance.

19 (5) PETITIONS.—

20 (A) PETITION PROCESS.—Effective on the  
21 date on which the provisions of this Act become  
22 effective, as provided for in section 601, a  
23 group health plan, health insurance issuer, par-  
24 ticipant, beneficiary, or enrollee may submit a  
25 petition to the Secretary for an advisory opinion

1 as to whether or not a standard or requirement  
2 under a State law applicable to the plan, issuer,  
3 participant, beneficiary, or enrollee that is not  
4 the subject of a certification under this sub-  
5 section, is superseded under subsection (a)(1)  
6 because such standard or requirement prevents  
7 the application of a requirement of this title.

8 (B) OPINION.—The Secretary shall issue  
9 an advisory opinion with respect to a petition  
10 submitted under subparagraph (A) within the  
11 60-day period beginning on the date on which  
12 such petition is submitted.

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

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

20 (2) STATE.—The term “State” includes a  
21 State, the District of Columbia, Puerto Rico, the  
22 Virgin Islands, Guam, American Samoa, the North-  
23 ern Mariana Islands, any political subdivisions of  
24 such, or any agency or instrumentality of such.

1 **SEC. 153. EXCLUSIONS.**

2 (a) NO BENEFIT REQUIREMENTS.—Nothing in this  
 3 title shall be construed to require a group health plan or  
 4 a health insurance issuer offering health insurance cov-  
 5 erage to include specific items and services under the  
 6 terms of such a plan or coverage, other than those pro-  
 7 vided under the terms and conditions of such plan or cov-  
 8 erage.

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

11 (1) IN GENERAL.—The provisions of sections  
 12 111 through 117 shall not apply to a group health  
 13 plan or health insurance coverage if the only cov-  
 14 erage offered under the plan or coverage is fee-for-  
 15 service coverage (as defined in paragraph (2)).

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

20 (A) reimburses hospitals, health profes-  
 21 sionals, and other providers on a fee-for-service  
 22 basis without placing the provider at financial  
 23 risk;

24 (B) does not vary reimbursement for such  
 25 a provider based on an agreement to contract

1 terms and conditions or the utilization of health  
 2 care items or services relating to such provider;

3 (C) allows access to any provider that is  
 4 lawfully authorized to provide the covered serv-  
 5 ices and that agrees to accept the terms and  
 6 conditions of payment established under the  
 7 plan or by the issuer; and

8 (D) for which the plan or issuer does not  
 9 require prior authorization before providing for  
 10 any health care services.

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

12 (a) IN GENERAL.—The requirements of this title and  
 13 the provisions of sections 502(a)(1)(C), 502(n), and  
 14 514(d) of the Employee Retirement Income Security Act  
 15 of 1974 (added by section 402) shall not apply to excepted  
 16 benefits (as defined in section 733(c) of such Act), other  
 17 than benefits described in section 733(c)(2)(A) of such  
 18 Act, in the same manner as the provisions of part 7 of  
 19 subtitle B of title I of such Act do not apply to such bene-  
 20 fits under subsections (b) and (c) of section 732 of such  
 21 Act.

22 (b) COVERAGE OF CERTAIN LIMITED SCOPE  
 23 PLANS.—Only for purposes of applying the requirements  
 24 of this title under sections 2707 and 2753 of the Public  
 25 Health Service Act, section 714 of the Employee Retire-



1 ment Income Security Act of 1974, and section 9813 of  
2 the Internal Revenue Code of 1986, the following sections  
3 shall be deemed not to apply:

4 (1) Section 2791(c)(2)(A) of the Public Health  
5 Service Act.

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

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

10 **SEC. 155. REGULATIONS.**

11 The Secretaries of Health and Human Services,  
12 Labor, and the Treasury shall issue such regulations as  
13 may be necessary or appropriate to carry out this title.  
14 Such regulations shall be issued consistent with section  
15 104 of Health Insurance Portability and Accountability  
16 Act of 1996. Such Secretaries may promulgate any in-  
17 terim final rules as the Secretaries determine are appro-  
18 priate to carry out this title.

19 **SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOC-**  
20 **UMENTS.**

21 The requirements of this title with respect to a group  
22 health plan or health insurance coverage are, subject to  
23 section 154, deemed to be incorporated into, and made  
24 a part of, such plan or the policy, certificate, or contract  
25 providing such coverage and are enforceable under law as

1 if directly included in the documentation of such plan or  
2 such policy, certificate, or contract.

3 **SEC. 157. PRESERVATION OF PROTECTIONS.**

4 (a) IN GENERAL.—The rights under this Act (includ-  
5 ing the right to maintain a civil action and any other  
6 rights under the amendments made by this Act) may not  
7 be waived, deferred, or lost pursuant to any agreement  
8 not authorized under this Act.

9 (b) EXCEPTION.—Subsection (a) shall not apply to  
10 an agreement providing for arbitration or participation in  
11 any other nonjudicial procedure to resolve a dispute if the  
12 agreement—

13 (1) is entered into knowingly and voluntarily by  
14 the parties involved after the dispute has arisen; or

15 (2) is pursuant to the terms of a collective bar-  
16 gaining agreement.

17 Nothing in this subsection shall be construed to permit  
18 the waiver of the requirements of sections 103 and 104  
19 (relating to internal and external review).

1 **TITLE II—APPLICATION OF**  
 2 **QUALITY CARE STANDARDS**  
 3 **TO GROUP HEALTH PLANS**  
 4 **AND HEALTH INSURANCE**  
 5 **COVERAGE UNDER THE PUB-**  
 6 **LIC HEALTH SERVICE ACT**

7 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**  
 8 **GROUP HEALTH INSURANCE COVERAGE.**

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

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

13 “Each group health plan shall comply with patient  
 14 protection requirements under title I of the Patients’ Bill  
 15 of Rights Act of 2005, and each health insurance issuer  
 16 shall comply with patient protection requirements under  
 17 such title with respect to group health insurance coverage  
 18 it offers, and such requirements shall be deemed to be in-  
 19 corporated into this subsection.”.

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

1 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**  
2 **ANCE COVERAGE.**

3 Part B of title XXVII of the Public Health Service  
4 Act is amended by inserting after section 2752 the fol-  
5 lowing new section:

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

7 “Each health insurance issuer shall comply with pa-  
8 tient protection requirements under title I of the Patients’  
9 Bill of Rights Act of 2005 with respect to individual health  
10 insurance coverage it offers, and such requirements shall  
11 be deemed to be incorporated into this subsection.”.

12 **SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE**  
13 **AUTHORITIES.**

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

17 **“SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE**  
18 **AUTHORITIES.**

19 “(a) AGREEMENT WITH STATES.—A State may  
20 enter into an agreement with the Secretary for the delega-  
21 tion to the State of some or all of the Secretary’s authority  
22 under this title to enforce the requirements applicable  
23 under title I of the Patients’ Bill of Rights Act of 2005  
24 with respect to health insurance coverage offered by a  
25 health insurance issuer and with respect to a group health  
26 plan that is a non-Federal governmental plan.

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

7       **TITLE III—APPLICATION OF PA-**  
 8       **TIENT PROTECTION STAND-**  
 9       **ARDS TO FEDERAL HEALTH**  
 10      **INSURANCE PROGRAMS**

11      **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**  
 12                      **ARDS TO FEDERAL HEALTH INSURANCE PRO-**  
 13                      **GRAMS.**

14      (a) SENSE OF CONGRESS.—It is the sense of Con-  
 15      gress that enrollees in Federal health insurance programs  
 16      should have the same rights and privileges as those af-  
 17      forded under title I and under the amendments made by  
 18      title IV to participants and beneficiaries under group  
 19      health plans.

20      (b) CONFORMING FEDERAL HEALTH INSURANCE  
 21      PROGRAMS.—It is the sense of Congress that the Presi-  
 22      dent should require, by executive order, the Federal offi-  
 23      cial with authority over each Federal health insurance pro-  
 24      gram, to the extent feasible, to take such steps as are nec-

1    essary to implement the rights and privileges described in  
2    subsection (a) with respect to such program.

3           (c) GAO REPORT ON ADDITIONAL STEPS RE-  
4    QUIRED.—Not later than 1 year after the date of the en-  
5    actment of this Act, the Comptroller General of the United  
6    States shall submit to Congress a report on statutory  
7    changes that are required to implement such rights and  
8    privileges in a manner that is consistent with the missions  
9    of the Federal health insurance programs and that avoids  
10   unnecessary duplication or disruption of such programs.

11          (d) FEDERAL HEALTH INSURANCE PROGRAM.—In  
12   this section, the term “Federal health insurance program”  
13   means a Federal program that provides creditable cov-  
14   erage (as defined in section 2701(c)(1) of the Public  
15   Health Service Act) and includes a health program of the  
16   Department of Veterans Affairs.

1 **TITLE IV—AMENDMENTS TO THE**  
 2 **EMPLOYEE RETIREMENT IN-**  
 3 **COME SECURITY ACT OF 1974**

4 **SEC. 401. APPLICATION OF PATIENT PROTECTION STAND-**  
 5 **ARDS TO GROUP HEALTH PLANS AND GROUP**  
 6 **HEALTH INSURANCE COVERAGE UNDER THE**  
 7 **EMPLOYEE RETIREMENT INCOME SECURITY**  
 8 **ACT OF 1974.**

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

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

13 “(a) IN GENERAL.—Subject to subsection (b), a  
 14 group health plan (and a health insurance issuer offering  
 15 group health insurance coverage in connection with such  
 16 a plan) shall comply with the requirements of title I of  
 17 the Patients’ Bill of Rights Act of 2005 (as in effect as  
 18 of the date of the enactment of such Act), and such re-  
 19 quirements shall be deemed to be incorporated into this  
 20 subsection.

21 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-  
 22 MENTS.—

23 “(1) SATISFACTION OF CERTAIN REQUIRE-  
 24 MENTS THROUGH INSURANCE.—For purposes of  
 25 subsection (a), insofar as a group health plan pro-

1       vides benefits in the form of health insurance cov-  
2       erage through a health insurance issuer, the plan  
3       shall be treated as meeting the following require-  
4       ments of title I of the Patients' Bill of Rights Act  
5       of 2005 with respect to such benefits and not be  
6       considered as failing to meet such requirements be-  
7       cause of a failure of the issuer to meet such require-  
8       ments so long as the plan sponsor or its representa-  
9       tives did not cause such failure by the issuer:

10               “(A) Section 111 (relating to consumer  
11               choice option).

12               “(B) Section 112 (relating to choice of  
13               health care professional).

14               “(C) Section 113 (relating to access to  
15               emergency care).

16               “(D) Section 114 (relating to timely access  
17               to specialists).

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

20               “(F) Section 116 (relating to access to pe-  
21               diatric care).

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



1           “(H) Section 118 (relating to access to  
2           needed prescription drugs).

3           “(I) Section 119 (relating to coverage for  
4           individuals participating in approved clinical  
5           trials).

6           “(J) Section 120 (relating to required cov-  
7           erage for minimum hospital stay for  
8           mastectomies and lymph node dissections for  
9           the treatment of breast cancer and coverage for  
10          secondary consultations).

11          “(K) Section 134 (relating to payment of  
12          claims).

13          “(2) INFORMATION.—With respect to informa-  
14          tion required to be provided or made available under  
15          section 121 of the Patients’ Bill of Rights Act of  
16          2005, in the case of a group health plan that pro-  
17          vides benefits in the form of health insurance cov-  
18          erage through a health insurance issuer, the Sec-  
19          retary shall determine the circumstances under  
20          which the plan is not required to provide or make  
21          available the information (and is not liable for the  
22          issuer’s failure to provide or make available the in-  
23          formation), if the issuer is obligated to provide and  
24          make available (or provides and makes available)  
25          such information.

1           “(3) INTERNAL APPEALS.—With respect to the  
2           internal appeals process required to be established  
3           under section 103 of such Act, in the case of a  
4           group health plan that provides benefits in the form  
5           of health insurance coverage through a health insur-  
6           ance issuer, the Secretary shall determine the cir-  
7           cumstances under which the plan is not required to  
8           provide for such process and system (and is not lia-  
9           ble for the issuer’s failure to provide for such proc-  
10          ess and system), if the issuer is obligated to provide  
11          for (and provides for) such process and system.

12          “(4) EXTERNAL APPEALS.—Pursuant to rules  
13          of the Secretary, insofar as a group health plan en-  
14          ters into a contract with a qualified external appeal  
15          entity for the conduct of external appeal activities in  
16          accordance with section 104 of such Act, the plan  
17          shall be treated as meeting the requirement of such  
18          section and is not liable for the entity’s failure to  
19          meet any requirements under such section.

20          “(5) APPLICATION TO PROHIBITIONS.—Pursu-  
21          ant to rules of the Secretary, if a health insurance  
22          issuer offers health insurance coverage in connection  
23          with a group health plan and takes an action in vio-  
24          lation of any of the following sections of the Pa-  
25          tients’ Bill of Rights Act of 2005, the group health

1 plan shall not be liable for such violation unless the  
2 plan caused such violation:

3 “(A) Section 131 (relating to prohibition of  
4 interference with certain medical communica-  
5 tions).

6 “(B) Section 132 (relating to prohibition  
7 of discrimination against providers based on li-  
8 censure).

9 “(C) Section 133 (relating to prohibition  
10 against improper incentive arrangements).

11 “(D) Section 135 (relating to protection  
12 for patient advocacy).

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

17 “(7) TREATMENT OF SUBSTANTIALLY COMPLI-  
18 ANT STATE LAWS.—For purposes of applying this  
19 subsection in connection with health insurance cov-  
20 erage, any reference in this subsection to a require-  
21 ment in a section or other provision in the Patients’  
22 Bill of Rights Act of 2005 with respect to a health  
23 insurance issuer is deemed to include a reference to  
24 a requirement under a State law that substantially  
25 complies (as determined under section 152(c) of

1 such Act) with the requirement in such section or  
2 other provisions.

3 “(8) APPLICATION TO CERTAIN PROHIBITIONS  
4 AGAINST RETALIATION.—With respect to compliance  
5 with the requirements of section 135(b)(1) of the  
6 Patients’ Bill of Rights Act of 2005, for purposes of  
7 this subtitle the term ‘group health plan’ is deemed  
8 to include a reference to an institutional health care  
9 provider.

10 “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

11 “(1) COMPLAINTS.—Any protected health care  
12 professional who believes that the professional has  
13 been retaliated or discriminated against in violation  
14 of section 135(b)(1) of the Patients’ Bill of Rights  
15 Act of 2005 may file with the Secretary a complaint  
16 within 180 days of the date of the alleged retaliation  
17 or discrimination.

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

1       “(d) CONFORMING REGULATIONS.—The Secretary  
 2 shall issue regulations to coordinate the requirements on  
 3 group health plans and health insurance issuers under this  
 4 section with the requirements imposed under the other  
 5 provisions of this title. In order to reduce duplication and  
 6 clarify the rights of participants and beneficiaries with re-  
 7 spect to information that is required to be provided, such  
 8 regulations shall coordinate the information disclosure re-  
 9 quirements under section 121 of the Patients’ Bill of  
 10 Rights Act of 2005 with the reporting and disclosure re-  
 11 quirements imposed under part 1, so long as such coordi-  
 12 nation does not result in any reduction in the information  
 13 that would otherwise be provided to participants and bene-  
 14 ficiaries.”.

15       (b) SATISFACTION OF ERISA CLAIMS PROCEDURE  
 16 REQUIREMENT.—Section 503 of such Act (29 U.S.C.  
 17 1133) is amended by inserting “(a)” after “Sec. 503.” and  
 18 by adding at the end the following new subsection:

19       “(b) In the case of a group health plan (as defined  
 20 in section 733), compliance with the requirements of sub-  
 21 title A of title I of the Patients’ Bill of Rights Act of 2005,  
 22 and compliance with regulations promulgated by the Sec-  
 23 retary, in the case of a claims denial, shall be deemed com-  
 24 pliance with subsection (a) with respect to such claims de-  
 25 nial.”.

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

4 (2) The table of contents in section 1 of such Act  
 5 is amended by inserting after the item relating to section  
 6 713 the following new item:

“714. Patient protection standards”.

7 (3) Section 502(b)(3) of such Act (29 U.S.C.  
 8 1132(b)(3)) is amended by inserting “(other than section  
 9 135(b) of the Patients’ Bill of Rights Act of 2005, as  
 10 deemed by subsection (a) of section 714 of this Act to  
 11 be incorporated into such subsection)” after “part 7”.

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

13 (a) AVAILABILITY OF FEDERAL CIVIL REMEDIES IN  
 14 CASES NOT INVOLVING MEDICALLY REVIEWABLE DECI-  
 15 SIONS.—

16 (1) IN GENERAL.—Section 502 of the Employee  
 17 Retirement Income Security Act of 1974 (29 U.S.C.  
 18 1132) is amended by adding at the end the following  
 19 new subsections:

20 “(n) CAUSE OF ACTION RELATING TO PROVISION OF  
 21 HEALTH BENEFITS.—

22 “(1) IN GENERAL.—In any case in which—

23 “(A) a person who is a fiduciary of a  
 24 group health plan, a health insurance issuer of-  
 25 fering health insurance coverage in connection

1 with the plan, or an agent of the plan, issuer,  
2 or plan sponsor, upon consideration of a claim  
3 for benefits of a participant or beneficiary  
4 under section 102 of the Patients' Bill of  
5 Rights Act of 2005 (relating to procedures for  
6 initial claims for benefits and prior authoriza-  
7 tion determinations) or upon review of a denial  
8 of such a claim under section 103 of such Act  
9 (relating to internal appeal of a denial of a  
10 claim for benefits), fails to exercise ordinary  
11 care in making a decision—

12 “(i) regarding whether an item or  
13 service is covered under the terms and con-  
14 ditions of the plan or coverage,

15 “(ii) regarding whether an individual  
16 is a participant or beneficiary who is en-  
17 rolled under the terms and conditions of  
18 the plan or coverage (including the applica-  
19 bility of any waiting period under the plan  
20 or coverage), or

21 “(iii) as to the application of cost-  
22 sharing requirements or the application of  
23 a specific exclusion or express limitation on  
24 the amount, duration, or scope of coverage

1 of items or services under the terms and  
 2 conditions of the plan or coverage, and

3 “(B) such failure is a proximate cause of  
 4 personal injury to, or the death of, the partici-  
 5 pant or beneficiary,  
 6 such plan, plan sponsor, or issuer shall be liable to  
 7 the participant or beneficiary (or the estate of such  
 8 participant or beneficiary) for economic and non-  
 9 economic damages (but not exemplary or punitive  
 10 damages) in connection with such personal injury or  
 11 death.

12 “(2) CAUSE OF ACTION MUST NOT INVOLVE  
 13 MEDICALLY REVIEWABLE DECISION.—

14 “(A) IN GENERAL.—A cause of action is  
 15 established under paragraph (1)(A) only if the  
 16 decision referred to in paragraph (1)(A) does  
 17 not include a medically reviewable decision.

18 “(B) MEDICALLY REVIEWABLE DECI-  
 19 SION.—For purposes of this subsection, the  
 20 term ‘medically reviewable decision’ means a de-  
 21 nial of a claim for benefits under the plan  
 22 which is described in section 104(d)(2) of the  
 23 Patients’ Bill of Rights Act of 2005 (relating to  
 24 medically reviewable decisions).



1           “(3) LIMITATION REGARDING CERTAIN TYPES  
 2           OF ACTIONS SAVED FROM PREEMPTION OF STATE  
 3           LAW.—A cause of action is not established under  
 4           paragraph (1)(A) in connection with a failure de-  
 5           scribed in paragraph (1)(A) to the extent that a  
 6           cause of action under State law (as defined in sec-  
 7           tion 514(c)) for such failure would not be preempted  
 8           under section 514.

9           “(4) DEFINITIONS AND RELATED RULES.—For  
 10          purposes of this subsection.—

11           “(A) ORDINARY CARE.—The term ‘ordi-  
 12          nary care’ means, with respect to a determina-  
 13          tion on a claim for benefits, that degree of care,  
 14          skill, and diligence that a reasonable and pru-  
 15          dent individual would exercise in making a fair  
 16          determination on a claim for benefits of like  
 17          kind to the claims involved.

18           “(B) PERSONAL INJURY.—The term ‘per-  
 19          sonal injury’ means a physical injury and in-  
 20          cludes an injury arising out of the treatment  
 21          (or failure to treat) a mental illness or disease.

22           “(C) CLAIM FOR BENEFITS; DENIAL.—The  
 23          terms ‘claim for benefits’ and ‘denial of a claim  
 24          for benefits’ have the meanings provided such

1 terms in section 102(e) of the Patients' Bill of  
 2 Rights Act of 2005.

3 “(D) TERMS AND CONDITIONS.—The term  
 4 ‘terms and conditions’ includes, with respect to  
 5 a group health plan or health insurance cov-  
 6 erage, requirements imposed under title I of the  
 7 Patients' Bill of Rights Act of 2005.

8 “(E) TREATMENT OF EXCEPTED BENE-  
 9 FITS.—Under section 154(a) of the Patients'  
 10 Bill of Rights Act of 2005, the provisions of  
 11 this subsection and subsection (a)(1)(C) do not  
 12 apply to certain excepted benefits.

13 “(5) EXCLUSION OF EMPLOYERS AND OTHER  
 14 PLAN SPONSORS.—

15 “(A) CAUSES OF ACTION AGAINST EM-  
 16 PLOYERS AND PLAN SPONSORS PRECLUDED.—  
 17 Subject to subparagraph (B), paragraph (1)(A)  
 18 does not authorize a cause of action against an  
 19 employer or other plan sponsor maintaining the  
 20 plan (or against an employee of such an em-  
 21 ployer or sponsor acting within the scope of em-  
 22 ployment).

23 “(B) CERTAIN CAUSES OF ACTION PER-  
 24 MITTED.—Notwithstanding subparagraph (A),  
 25 a cause of action may arise against an employer

1 or other plan sponsor (or against an employee  
2 of such an employer or sponsor acting within  
3 the scope of employment) under paragraph  
4 (1)(A), to the extent there was direct participa-  
5 tion by the employer or other plan sponsor (or  
6 employee) in the decision of the plan under sec-  
7 tion 102 of the Patients’ Bill of Rights Act of  
8 2005 upon consideration of a claim for benefits  
9 or under section 103 of such Act upon review  
10 of a denial of a claim for benefits.

11 “(C) DIRECT PARTICIPATION.—

12 “(i) IN GENERAL.—For purposes of  
13 subparagraph (B), the term ‘direct partici-  
14 pation’ means, in connection with a deci-  
15 sion described in paragraph (1)(A), the ac-  
16 tual making of such decision or the actual  
17 exercise of control in making such decision.

18 “(ii) RULES OF CONSTRUCTION.—For  
19 purposes of clause (i), the employer or plan  
20 sponsor (or employee) shall not be con-  
21 strued to be engaged in direct participation  
22 because of any form of decisionmaking or  
23 other conduct that is merely collateral or  
24 precedent to the decision described in  
25 paragraph (1)(A) on a particular claim for

benefits of a participant or beneficiary, including (but not limited to)—

“(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

“(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

“(III) any participation by the employer or other plan sponsor (or employee) in the process of creating, continuing, modifying, or terminating the plan or any benefit under the plan, if such process was not substantially focused solely on the particular situation of the participant or beneficiary referred to in paragraph (1)(A); and

1           “(IV) any participation by the  
2           employer or other plan sponsor (or  
3           employee) in the design of any benefit  
4           under the plan, including the amount  
5           of copayment and limits connected  
6           with such benefit.

7           “(iii) IRRELEVANCE OF CERTAIN COL-  
8           LATERAL EFFORTS MADE BY EMPLOYER  
9           OR PLAN SPONSOR.—For purposes of this  
10          subparagraph, an employer or plan sponsor  
11          shall not be treated as engaged in direct  
12          participation in a decision with respect to  
13          any claim for benefits or denial thereof in  
14          the case of any particular participant or  
15          beneficiary solely by reason of—

16               “(I) any efforts that may have  
17               been made by the employer or plan  
18               sponsor to advocate for authorization  
19               of coverage for that or any other par-  
20               ticipant or beneficiary (or any group  
21               of participants or beneficiaries), or

22               “(II) any provision that may  
23               have been made by the employer or  
24               plan sponsor for benefits which are  
25               not covered under the terms and con-

ditions of the plan for that or any other participant or beneficiary (or any group of participants or beneficiaries).

“(D) APPLICATION TO CERTAIN PLANS.—

“(i) IN GENERAL.—Notwithstanding any other provision of this subsection, no group health plan described in clause (ii) (or plan sponsor of such a plan) shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty under the plan.

“(ii) DEFINITION.—A group health plan described in this clause is—

“(I) a group health plan that is self-insured and self administered by an employer (including an employee of such an employer acting within the scope of employment); or

“(II) a multiemployer plan as defined in section 3(37)(A) (including an employee of a contributing employer or of the plan, or a fiduciary of the plan, acting within the scope of employment or fiduciary responsi-

1 bility) that is self-insured and self-ad-  
 2 ministered.

3 “(6) EXCLUSION OF PHYSICIANS AND OTHER  
 4 HEALTH CARE PROFESSIONALS.—

5 “(A) IN GENERAL.—No treating physician  
 6 or other treating health care professional of the  
 7 participant or beneficiary, and no person acting  
 8 under the direction of such a physician or  
 9 health care professional, shall be liable under  
 10 paragraph (1) for the performance of, or the  
 11 failure to perform, any non-medically reviewable  
 12 duty of the plan, the plan sponsor, or any  
 13 health insurance issuer offering health insur-  
 14 ance coverage in connection with the plan.

15 “(B) DEFINITIONS.—For purposes of sub-  
 16 paragraph (A)—

17 “(i) HEALTH CARE PROFESSIONAL.—  
 18 The term ‘health care professional’ means  
 19 an individual who is licensed, accredited, or  
 20 certified under State law to provide speci-  
 21 fied health care services and who is oper-  
 22 ating within the scope of such licensure,  
 23 accreditation, or certification.

24 “(ii) NON-MEDICALLY REVIEWABLE  
 25 DUTY.—The term ‘non-medically review-

1           able duty’ means a duty the discharge of  
 2           which does not include the making of a  
 3           medically reviewable decision.

4           “(7) EXCLUSION OF HOSPITALS.—No treating  
 5           hospital of the participant or beneficiary shall be lia-  
 6           ble under paragraph (1) for the performance of, or  
 7           the failure to perform, any non-medically reviewable  
 8           duty (as defined in paragraph (6)(B)(ii)) of the  
 9           plan, the plan sponsor, or any health insurance  
 10          issuer offering health insurance coverage in connec-  
 11          tion with the plan.

12          “(8) RULE OF CONSTRUCTION RELATING TO  
 13          EXCLUSION FROM LIABILITY OF PHYSICIANS,  
 14          HEALTH CARE PROFESSIONALS, AND HOSPITALS.—  
 15          Nothing in paragraph (6) or (7) shall be construed  
 16          to limit the liability (whether direct or vicarious) of  
 17          the plan, the plan sponsor, or any health insurance  
 18          issuer offering health insurance coverage in connec-  
 19          tion with the plan.

20          “(9) REQUIREMENT OF EXHAUSTION.—

21                 “(A) IN GENERAL.—A cause of action may  
 22                 not be brought under paragraph (1) in connec-  
 23                 tion with any denial of a claim for benefits of  
 24                 any individual until all administrative processes  
 25                 under sections 102 and 103 of the Patients’



1 Bill of Rights Act of 2005 (if applicable) have  
2 been exhausted.

3 “(B) EXCEPTION FOR NEEDED CARE.—A  
4 participant or beneficiary may seek relief exclu-  
5 sively in Federal court under subsection  
6 502(a)(1)(B) prior to the exhaustion of admin-  
7 istrative remedies under sections 102, 103, or  
8 104 of the Patients’ Bill of Rights Act of 2005  
9 (as required under subparagraph (A)) if it is  
10 demonstrated to the court that the exhaustion  
11 of such remedies would cause irreparable harm  
12 to the health of the participant or beneficiary.  
13 Notwithstanding the awarding of relief under  
14 subsection 502(a)(1)(B) pursuant to this sub-  
15 paragraph, no relief shall be available as a re-  
16 sult of, or arising under, paragraph (1)(A) or  
17 paragraph (10)(B), with respect to a partici-  
18 pant or beneficiary, unless the requirements of  
19 subparagraph (A) are met.

20 “(C) RECEIPT OF BENEFITS DURING AP-  
21 PEALS PROCESS.—Receipt by the participant or  
22 beneficiary of the benefits involved in the claim  
23 for benefits during the pendency of any admin-  
24 istrative processes referred to in subparagraph

(A) or of any action commenced under this subsection—

“(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

“(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

“(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Patients’ Bill of Rights Act of 2005 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

“(10) STATUTORY DAMAGES.—

“(A) IN GENERAL.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection.

“(B) ASSESSMENT OF CIVIL PENALTIES.—

In addition to the remedies provided for in paragraph (1) (relating to the failure to provide contract benefits in accordance with the plan), a civil assessment, in an amount not to exceed \$5,000,000, payable to the claimant may be awarded in any action under such paragraph if the claimant establishes by clear and convincing evidence that the alleged conduct carried out by the defendant demonstrated bad faith and flagrant disregard for the rights of the participant or beneficiary under the plan and was a proximate cause of the personal injury or death that is the subject of the claim.

“(11) LIMITATION ON ATTORNEYS’ FEES.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney’s fee, the amount of an attorney’s contingency fee allowable for a cause of action brought pursuant to this subsection shall not exceed  $\frac{1}{3}$  of the total amount of the plaintiff’s recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

1                   “(B) DETERMINATION BY DISTRICT  
 2 COURT.—The last Federal district court in  
 3 which the action was pending upon the final  
 4 disposition, including all appeals, of the action  
 5 shall have jurisdiction to review the attorney’s  
 6 fee to ensure that the fee is a reasonable one.

7                   “(12) LIMITATION OF ACTION.—Paragraph (1)  
 8 shall not apply in connection with any action com-  
 9 menced after 3 years after the later of—

10                   “(A) the date on which the plaintiff first  
 11 knew, or reasonably should have known, of the  
 12 personal injury or death resulting from the fail-  
 13 ure described in paragraph (1), or

14                   “(B) the date as of which the requirements  
 15 of paragraph (9) are first met.

16                   “(13) TOLLING PROVISION.—The statute of  
 17 limitations for any cause of action arising under  
 18 State law relating to a denial of a claim for benefits  
 19 that is the subject of an action brought in Federal  
 20 court under this subsection shall be tolled until such  
 21 time as the Federal court makes a final disposition,  
 22 including all appeals, of whether such claim should  
 23 properly be within the jurisdiction of the Federal  
 24 court. The tolling period shall be determined by the

1 applicable Federal or State law, whichever period is  
2 greater.

3 “(14) PURCHASE OF INSURANCE TO COVER LI-  
4 ABILITY.—Nothing in section 410 shall be construed  
5 to preclude the purchase by a group health plan of  
6 insurance to cover any liability or losses arising  
7 under a cause of action under subsection (a)(1)(C)  
8 and this subsection.

9 “(15) EXCLUSION OF DIRECTED RECORD-  
10 KEEPERS.—

11 “(A) IN GENERAL.—Subject to subpara-  
12 graph (C), paragraph (1) shall not apply with  
13 respect to a directed recordkeeper in connection  
14 with a group health plan.

15 “(B) DIRECTED RECORDKEEPER.—For  
16 purposes of this paragraph, the term ‘directed  
17 recordkeeper’ means, in connection with a  
18 group health plan, a person engaged in directed  
19 recordkeeping activities pursuant to the specific  
20 instructions of the plan or the employer or  
21 other plan sponsor, including the distribution of  
22 enrollment information and distribution of dis-  
23 closure materials under this Act or title I of the  
24 Patients’ Bill of Rights Act of 2005 and whose

1 duties do not include making decisions on  
2 claims for benefits.

3 “(C) LIMITATION.—Subparagraph (A)  
4 does not apply in connection with any directed  
5 recordkeeper to the extent that the directed rec-  
6 ordkeeper fails to follow the specific instruction  
7 of the plan or the employer or other plan spon-  
8 sor.

9 “(16) EXCLUSION OF HEALTH INSURANCE  
10 AGENTS.—Paragraph (1) does not apply with re-  
11 spect to a person whose sole involvement with the  
12 group health plan is providing advice or administra-  
13 tive services to the employer or other plan sponsor  
14 relating to the selection of health insurance coverage  
15 offered in connection with the plan.

16 “(17) NO EFFECT ON STATE LAW.—No provi-  
17 sion of State law (as defined in section 514(c)(1))  
18 shall be treated as superseded or otherwise altered,  
19 amended, modified, invalidated, or impaired by rea-  
20 son of the provisions of subsection (a)(1)(C) and this  
21 subsection.

22 “(18) RELIEF FROM LIABILITY FOR EMPLOYER  
23 OR OTHER PLAN SPONSOR BY MEANS OF DES-  
24 IGNATED DECISIONMAKER.—

1           “(A) IN GENERAL.—Notwithstanding the  
2           direct participation (as defined in paragraph  
3           (5)(C)(i)) of an employer or plan sponsor, in  
4           any case in which there is (or is deemed under  
5           subparagraph (B) to be) a designated decision-  
6           maker under subparagraph (B) that meets the  
7           requirements of subsection (o)(1) for an em-  
8           ployer or other plan sponsor—

9           “(i) all liability of such employer or  
10          plan sponsor involved (and any employee of  
11          such employer or sponsor acting within the  
12          scope of employment) under this sub-  
13          section in connection with any participant  
14          or beneficiary shall be transferred to, and  
15          assumed by, the designated decisionmaker,  
16          and

17          “(ii) with respect to such liability, the  
18          designated decisionmaker shall be sub-  
19          stituted for the employer or sponsor (or  
20          employee) in the action and may not raise  
21          any defense that the employer or sponsor  
22          (or employee) could not raise if such a de-  
23          cisionmaker were not so deemed.

24          “(B) AUTOMATIC DESIGNATION.—A health  
25          insurance issuer shall be deemed to be a des-

1           ignated decisionmaker for purposes of subpara-  
 2           graph (A) with respect to the participants and  
 3           beneficiaries of an employer or plan sponsor,  
 4           whether or not the employer or plan sponsor  
 5           makes such a designation, and shall be deemed  
 6           to have assumed unconditionally all liability of  
 7           the employer or plan sponsor under such des-  
 8           ignation in accordance with subsection (o), un-  
 9           less the employer or plan sponsor affirmatively  
 10          enters into a contract to prevent the service of  
 11          the designated decisionmaker.

12           “(C) TREATMENT OF CERTAIN TRUST  
 13          FUNDS.—For purposes of this paragraph, the  
 14          terms ‘employer’ and ‘plan sponsor’, in connec-  
 15          tion with the assumption by a designated deci-  
 16          sionmaker of the liability of employer or other  
 17          plan sponsor pursuant to this paragraph, shall  
 18          be construed to include a trust fund maintained  
 19          pursuant to section 302 of the Labor Manage-  
 20          ment Relations Act, 1947 (29 U.S.C. 186) or  
 21          the Railway Labor Act (45 U.S.C. 151 et seq.).

22          “(19) PREVIOUSLY PROVIDED SERVICES.—

23           “(A) IN GENERAL.—Except as provided in  
 24          this paragraph, a cause of action shall not arise  
 25          under paragraph (1) where the denial involved



1 relates to an item or service that has already  
2 been fully provided to the participant or bene-  
3 ficiary under the plan or coverage and the claim  
4 relates solely to the subsequent denial of pay-  
5 ment for the provision of such item or service.

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

8 “(i) prohibit a cause of action under  
9 paragraph (1) where the nonpayment in-  
10 volved results in the participant or bene-  
11 ficiary being unable to receive further  
12 items or services that are directly related  
13 to the item or service involved in the denial  
14 referred to in subparagraph (A) or that  
15 are part of a continuing treatment or se-  
16 ries of procedures; or

17 “(ii) limit liability that otherwise  
18 would arise from the provision of the item  
19 or services or the performance of a medical  
20 procedure.

21 “(20) EXEMPTION FROM PERSONAL LIABILITY  
22 FOR INDIVIDUAL MEMBERS OF BOARDS OF DIREC-  
23 TORS, JOINT BOARDS OF TRUSTEES, ETC.—Any indi-  
24 vidual who is—

1           “(A) a member of a board of directors of  
2           an employer or plan sponsor; or

3           “(B) a member of an association, com-  
4           mittee, employee organization, joint board of  
5           trustees, or other similar group of representa-  
6           tives of the entities that are the plan sponsor  
7           of plan maintained by two or more employers  
8           and one or more employee organizations;

9           shall not be personally liable under this subsection  
10          for conduct that is within the scope of employment  
11          or of plan-related duties of the individuals unless the  
12          individual acts in a fraudulent manner for personal  
13          enrichment.

14          “(o) REQUIREMENTS FOR DESIGNATED DECISION-  
15          MAKERS OF GROUP HEALTH PLANS.—

16               “(1) IN GENERAL.—For purposes of subsection  
17          (n)(18) and section 514(d)(9), a designated decision-  
18          maker meets the requirements of this paragraph  
19          with respect to any participant or beneficiary if—

20                       “(A) such designation is in such form as  
21                       may be prescribed in regulations of the Sec-  
22                       retary,

23                       “(B) the designated decisionmaker—

24                               “(i) meets the requirements of para-  
25                               graph (2),

1 “(ii) assumes unconditionally all liabil-  
2 ity of the employer or plan sponsor in-  
3 volved (and any employee of such employer  
4 or sponsor acting within the scope of em-  
5 ployment) either arising under subsection  
6 (n) or arising in a cause of action per-  
7 mitted under section 514(d) in connection  
8 with actions (and failures to act) of the  
9 employer or plan sponsor (or employee) oc-  
10 ccurring during the period in which the des-  
11 ignation under subsection (n)(18) or sec-  
12 tion 514(d)(9) is in effect relating to such  
13 participant and beneficiary,

14 “(iii) agrees to be substituted for the  
15 employer or plan sponsor (or employee) in  
16 the action and not to raise any defense  
17 with respect to such liability that the em-  
18 ployer or plan sponsor (or employee) may  
19 not raise, and

20 “(iv) where paragraph (2)(B) applies,  
21 assumes unconditionally the exclusive au-  
22 thority under the group health plan to  
23 make medically reviewable decisions under  
24 the plan with respect to such participant  
25 or beneficiary, and

“(C) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 402(a) and as required under section 121(b)(19) of the Patients’ Bill of Rights Act of 2005.

Any liability assumed by a designated decisionmaker pursuant to this subsection shall be in addition to any liability that it may otherwise have under applicable law.

“(2) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

“(A) IN GENERAL.—Subject to subparagraph (B), an entity is qualified under this paragraph to serve as a designated decisionmaker with respect to a group health plan if the entity has the ability to assume the liability described in paragraph (1) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor and the Secretary certification of such ability. Such certification shall be provided to the plan spon-

1           sor or named fiduciary and to the Secretary  
2           upon designation under subsection (n)(18)(B)  
3           or section 517(d)(9)(B) and not less frequently  
4           than annually thereafter, or if such designation  
5           constitutes a multiyear arrangement, in con-  
6           junction with the renewal of the arrangement.

7           “(B) SPECIAL QUALIFICATION IN THE  
8           CASE OF CERTAIN REVIEWABLE DECISIONS.—In  
9           the case of a group health plan that provides  
10          benefits consisting of medical care to a partici-  
11          pant or beneficiary only through health insur-  
12          ance coverage offered by a single health insur-  
13          ance issuer, such issuer is the only entity that  
14          may be qualified under this paragraph to serve  
15          as a designated decisionmaker with respect to  
16          such participant or beneficiary, and shall serve  
17          as the designated decisionmaker unless the em-  
18          ployer or other plan sponsor acts affirmatively  
19          to prevent such service.

20          “(3) REQUIREMENTS RELATING TO FINANCIAL  
21          OBLIGATIONS.—For purposes of paragraph (2)(A),  
22          the requirements relating to the financial obligation  
23          of an entity for liability shall include—

24                 “(A) coverage of such entity under an in-  
25                 surance policy or other arrangement, secured

1 and maintained by such entity, to effectively in-  
2 sure such entity against losses arising from pro-  
3 fessional liability claims, including those arising  
4 from its service as a designated decisionmaker  
5 under this part; or

6 “(B) evidence of minimum capital and sur-  
7 plus levels that are maintained by such entity  
8 to cover any losses as a result of liability arising  
9 from its service as a designated decisionmaker  
10 under this part.

11 The appropriate amounts of liability insurance and  
12 minimum capital and surplus levels for purposes of  
13 subparagraphs (A) and (B) shall be determined by  
14 an actuary using sound actuarial principles and ac-  
15 counting practices pursuant to established guidelines  
16 of the American Academy of Actuaries and in ac-  
17 cordance with such regulations as the Secretary may  
18 prescribe and shall be maintained throughout the  
19 term for which the designation is in effect. The pro-  
20 visions of this paragraph shall not apply in the case  
21 of a designated decisionmaker that is a group health  
22 plan, plan sponsor, or health insurance issuer and  
23 that is regulated under Federal law or a State finan-  
24 cial solvency law.

1           “(4) LIMITATION ON APPOINTMENT OF TREAT-  
 2           ING PHYSICIANS.—A treating physician who directly  
 3           delivered the care, treatment, or provided the patient  
 4           service that is the subject of a cause of action by a  
 5           participant or beneficiary under subsection (n) or  
 6           section 514(d) may not be designated as a des-  
 7           ignated decisionmaker under this subsection with re-  
 8           spect to such participant or beneficiary.”.

9           (2)     CONFORMING     AMENDMENT.—Section  
 10          502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is  
 11          amended—

12                 (A) by striking “or” at the end of subpara-  
 13          graph (A);

14                 (B) in subparagraph (B), by striking  
 15          “plan;” and inserting “plan, or”; and

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

18                         “(C) for the relief provided for in sub-  
 19          section (n) of this section.”.

20          (b) RULES RELATING TO ERISA PREEMPTION.—  
 21          Section 514 of the Employee Retirement Income Security  
 22          Act of 1974 (29 U.S.C. 1144) is amended—

23                 (1) by redesignating subsection (d) as sub-  
 24          section (f); and

1           (2) by inserting after subsection (c) the fol-  
 2           lowing new subsections:

3           “(d) PREEMPTION NOT TO APPLY TO CAUSES OF AC-  
 4           TION UNDER STATE LAW INVOLVING MEDICALLY RE-  
 5           VIEWABLE DECISION.—

6           “(1) NON-PREEMPTION OF CERTAIN CAUSES OF  
 7           ACTION.—

8           “(A) IN GENERAL.—Except as provided in  
 9           this subsection, nothing in this title (including  
 10          section 502) shall be construed to supersede or  
 11          otherwise alter, amend, modify, invalidate, or  
 12          impair any cause of action under State law of  
 13          a participant or beneficiary under a group  
 14          health plan (or the estate of such a participant  
 15          or beneficiary) against the plan, the plan spon-  
 16          sor, any health insurance issuer offering health  
 17          insurance coverage in connection with the plan,  
 18          or any managed care entity in connection with  
 19          the plan to recover damages resulting from per-  
 20          sonal injury or for wrongful death if such cause  
 21          of action arises by reason of a medically review-  
 22          able decision.

23          “(B) MEDICALLY REVIEWABLE DECI-  
 24          SION.—For purposes of subparagraph (A), the  
 25          term ‘medically reviewable decision’ means a de-



1           nial of a claim for benefits under the plan  
 2           which is described in section 104(d)(2) of the  
 3           Patients' Bill of Rights Act of 2005 (relating to  
 4           medically reviewable decisions).

5           “(C) LIMITATION ON PUNITIVE DAM-  
 6           AGES.—

7                   “(i) IN GENERAL.—Except as pro-  
 8                   vided in clauses (ii) and (iii), with respect  
 9                   to a cause of action described in subpara-  
 10                  graph (A) brought with respect to a partic-  
 11                  ipant or beneficiary, State law is super-  
 12                  seded insofar as it provides any punitive,  
 13                  exemplary, or similar damages if, as of the  
 14                  time of the personal injury or death, all  
 15                  the requirements of the following sections  
 16                  of the Patients' Bill of Rights Act of 2005  
 17                  were satisfied with respect to the partici-  
 18                  pant or beneficiary:

19                           “(I) Section 102 (relating to pro-  
 20                           cedures for initial claims for benefits  
 21                           and prior authorization determina-  
 22                           tions).

23                           “(II) Section 103 of such Act  
 24                           (relating to internal appeals of claims  
 25                           denials).

1                   “(III) Section 104 of such Act  
2                   (relating to independent external ap-  
3                   peals procedures).

4                   “(ii) EXCEPTION FOR CERTAIN AC-  
5                   TIONS FOR WRONGFUL DEATH.—Clause (i)  
6                   shall not apply with respect to an action  
7                   for wrongful death if the applicable State  
8                   law provides (or has been construed to pro-  
9                   vide) for damages in such an action which  
10                  are only punitive or exemplary in nature.

11                  “(iii) EXCEPTION FOR WILLFUL OR  
12                  WANTON DISREGARD FOR THE RIGHTS OR  
13                  SAFETY OF OTHERS.—Clause (i) shall not  
14                  apply with respect to any cause of action  
15                  described in subparagraph (A) if, in such  
16                  action, the plaintiff establishes by clear  
17                  and convincing evidence that conduct car-  
18                  ried out by the defendant with willful or  
19                  wanton disregard for the rights or safety  
20                  of others was a proximate cause of the per-  
21                  sonal injury or wrongful death that is the  
22                  subject of the action.

23                  “(2) DEFINITIONS AND RELATED RULES.—For  
24                  purposes of this subsection and subsection (e)—

1           “(A) TREATMENT OF EXCEPTED BENE-  
2           FITS.—Under section 154(a) of the Patients’  
3           Bill of Rights Act of 2005, the provisions of  
4           this subsection do not apply to certain excepted  
5           benefits.

6           “(B) PERSONAL INJURY.—The term ‘per-  
7           sonal injury’ means a physical injury and in-  
8           cludes an injury arising out of the treatment  
9           (or failure to treat) a mental illness or disease.

10          “(C) CLAIM FOR BENEFIT; DENIAL.—The  
11          terms ‘claim for benefits’ and ‘denial of a claim  
12          for benefits’ shall have the meaning provided  
13          such terms under section 102(e) of the Pa-  
14          tients’ Bill of Rights Act of 2005.

15          “(D) MANAGED CARE ENTITY.—

16               “(i) IN GENERAL.—The term ‘man-  
17               aged care entity’ means, in connection with  
18               a group health plan and subject to clause  
19               (ii), any entity that is involved in deter-  
20               mining the manner in which or the extent  
21               to which items or services (or reimburse-  
22               ment therefor) are to be provided as bene-  
23               fits under the plan.

24               “(ii) TREATMENT OF TREATING PHY-  
25               SICIANS, OTHER TREATING HEALTH CARE

1           PROFESSIONALS, AND TREATING HOS-  
 2           PITALS.—Such term does not include a  
 3           treating physician or other treating health  
 4           care professional (as defined in section  
 5           502(n)(6)(B)(i)) of the participant or ben-  
 6           eficiary and also does not include a treat-  
 7           ing hospital insofar as it is acting solely in  
 8           the capacity of providing treatment or care  
 9           to the participant or beneficiary. Nothing  
 10          in the preceding sentence shall be con-  
 11          strued to preempt vicarious liability of any  
 12          plan, plan sponsor, health insurance issuer,  
 13          or managed care entity.

14          “(3) EXCLUSION OF EMPLOYERS AND OTHER  
 15          PLAN SPONSORS.—

16               “(A) CAUSES OF ACTION AGAINST EM-  
 17          PLOYERS AND PLAN SPONSORS PRECLUDED.—  
 18          Subject to subparagraph (B), paragraph (1)  
 19          does not apply with respect to—

20                   “(i) any cause of action against an  
 21                  employer or other plan sponsor maintain-  
 22                  ing the plan (or against an employee of  
 23                  such an employer or sponsor acting within  
 24                  the scope of employment), or

1           “(ii) a right of recovery, indemnity, or  
2           contribution by a person against an em-  
3           ployer or other plan sponsor (or such an  
4           employee) for damages assessed against  
5           the person pursuant to a cause of action to  
6           which paragraph (1) applies.

7           “(B) CERTAIN CAUSES OF ACTION PER-  
8           MITTED.—Notwithstanding subparagraph (A),  
9           paragraph (1) applies with respect to any cause  
10          of action that is brought by a participant or  
11          beneficiary under a group health plan (or the  
12          estate of such a participant or beneficiary) to  
13          recover damages resulting from personal injury  
14          or for wrongful death against any employer or  
15          other plan sponsor maintaining the plan (or  
16          against an employee of such an employer or  
17          sponsor acting within the scope of employment)  
18          if such cause of action arises by reason of a  
19          medically reviewable decision, to the extent that  
20          there was direct participation by the employer  
21          or other plan sponsor (or employee) in the deci-  
22          sion.

23          “(C) DIRECT PARTICIPATION.—

24                 “(i) DIRECT PARTICIPATION IN DECI-  
25                 SIONS.—For purposes of subparagraph

(B), the term ‘direct participation’ means, in connection with a decision described in subparagraph (B), the actual making of such decision or the actual exercise of control in making such decision or in the conduct constituting the failure.

“(ii) RULES OF CONSTRUCTION.—For purposes of clause (i), the employer or plan sponsor (or employee) shall not be construed to be engaged in direct participation because of any form of decisionmaking or other conduct that is merely collateral or precedent to the decision described in subparagraph (B) on a particular claim for benefits of a particular participant or beneficiary, including (but not limited to)—

“(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

“(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis

1 undertaken in connection with the se-  
2 lection of, or continued maintenance  
3 of, the plan or coverage involved;

4 “(III) any participation by the  
5 employer or other plan sponsor (or  
6 employee) in the process of creating,  
7 continuing, modifying, or terminating  
8 the plan or any benefit under the  
9 plan, if such process was not substan-  
10 tially focused solely on the particular  
11 situation of the participant or bene-  
12 ficiary referred to in paragraph  
13 (1)(A); and

14 “(IV) any participation by the  
15 employer or other plan sponsor (or  
16 employee) in the design of any benefit  
17 under the plan, including the amount  
18 of copayment and limits connected  
19 with such benefit.

20 “(iv) IRRELEVANCE OF CERTAIN COL-  
21 LATERAL EFFORTS MADE BY EMPLOYER  
22 OR PLAN SPONSOR.—For purposes of this  
23 subparagraph, an employer or plan sponsor  
24 shall not be treated as engaged in direct  
25 participation in a decision with respect to

1           any claim for benefits or denial thereof in  
2           the case of any particular participant or  
3           beneficiary solely by reason of—

4                   “(I) any efforts that may have  
5                   been made by the employer or plan  
6                   sponsor to advocate for authorization  
7                   of coverage for that or any other par-  
8                   ticipant or beneficiary (or any group  
9                   of participants or beneficiaries), or

10                   “(II) any provision that may  
11                   have been made by the employer or  
12                   plan sponsor for benefits which are  
13                   not covered under the terms and con-  
14                   ditions of the plan for that or any  
15                   other participant or beneficiary (or  
16                   any group of participants or bene-  
17                   ficiaries).

18           “(4) REQUIREMENT OF EXHAUSTION.—

19                   “(A) IN GENERAL.—Except as provided in  
20                   subparagraph (D), paragraph (1) shall not  
21                   apply in connection with any action in connec-  
22                   tion with any denial of a claim for benefits of  
23                   any individual until all administrative processes  
24                   under sections 102, 103, and 104 of the Pa-



1           tients’ Bill of Rights Act of 2005 (if applicable)  
2           have been exhausted.

3           “(B) LATE MANIFESTATION OF INJURY.—

4                   “(i) IN GENERAL.—A participant or  
5           beneficiary shall not be precluded from  
6           pursuing a review under section 104 of the  
7           Patients’ Bill of Rights Act of 2005 re-  
8           garding an injury that such participant or  
9           beneficiary has experienced if the external  
10          review entity first determines that the in-  
11          jury of such participant or beneficiary is a  
12          late manifestation of an earlier injury.

13                   “(ii) DEFINITION.—In this subpara-  
14          graph, the term ‘late manifestation of an  
15          earlier injury’ means an injury sustained  
16          by the participant or beneficiary which was  
17          not known, and should not have been  
18          known, by such participant or beneficiary  
19          by the latest date that the requirements of  
20          subparagraph (A) should have been met  
21          regarding the claim for benefits which was  
22          denied.

23           “(C) EXCEPTION FOR NEEDED CARE.—A  
24          participant or beneficiary may seek relief exclu-  
25          sively in Federal court under subsection

1           502(a)(1)(B) prior to the exhaustion of admin-  
2           istrative remedies under sections 102, 103, or  
3           104 of the Patients' Bill of Rights Act of 2005  
4           (as required under subparagraph (A)) if it is  
5           demonstrated to the court that the exhaustion  
6           of such remedies would cause irreparable harm  
7           to the health of the participant or beneficiary.  
8           Notwithstanding the awarding of relief under  
9           subsection 502(a)(1)(B) pursuant to this sub-  
10          paragraph, no relief shall be available as a re-  
11          sult of, or arising under, paragraph (1)(A) un-  
12          less the requirements of subparagraph (A) are  
13          met.

14           “(D) FAILURE TO REVIEW.—

15                   “(i) IN GENERAL.—If the external re-  
16                   view entity fails to make a determination  
17                   within the time required under section  
18                   104(e)(1)(A)(i) of the Patients' Bill of  
19                   Rights Act of 2005, subparagraph (A)  
20                   shall not apply with respect to the action  
21                   after 10 additional days after the date on  
22                   which such time period has expired and the  
23                   filing of such action shall not affect the  
24                   duty of the independent medical reviewer

(or reviewers) to make a determination pursuant to such section 104(e)(1)(A)(i).

“(ii) EXPEDITED DETERMINATION.—

If the external review entity fails to make a determination within the time required under section 104(e)(1)(A)(ii) of the Patients’ Bill of Rights Act of 2005, subparagraph (A) shall not apply with respect to the action and the filing of such an action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to such section 104(e)(1)(A)(ii).

“(E) RECEIPT OF BENEFITS DURING AP-

PEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or the pendency of any action with respect to which, under this paragraph, subparagraph (A) does not apply—

“(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

1           “(ii) shall not preclude any liability  
2           under subsection (a)(1)(C) and this sub-  
3           section in connection with such claim.

4           “(F) ADMISSIBLE.—Any determination  
5           made by a reviewer in an administrative pro-  
6           ceeding under section 104 of the Patients’ Bill  
7           of Rights Act of 2005 shall be admissible in  
8           any Federal or State court proceeding and shall  
9           be presented to the trier of fact.

10          “(5) TOLLING PROVISION.—The statute of limi-  
11          tations for any cause of action arising under section  
12          502(n) relating to a denial of a claim for benefits  
13          that is the subject of an action brought in State  
14          court shall be tolled until such time as the State  
15          court makes a final disposition, including all ap-  
16          peals, of whether such claim should properly be  
17          within the jurisdiction of the State court. The tolling  
18          period shall be determined by the applicable Federal  
19          or State law, whichever period is greater.

20          “(6) EXCLUSION OF DIRECTED RECORD-  
21          KEEPERS.—

22          “(A) IN GENERAL.—Subject to subpara-  
23          graph (C), paragraph (1) shall not apply with  
24          respect to any action against a directed record-  
25          keeper in connection with a group health plan.

1           “(B) DIRECTED RECORDKEEPER.—For  
2 purposes of this paragraph, the term ‘directed  
3 recordkeeper’ means, in connection with a  
4 group health plan, a person engaged in directed  
5 recordkeeping activities pursuant to the specific  
6 instructions of the plan or the employer or  
7 other plan sponsor, including the distribution of  
8 enrollment information and distribution of dis-  
9 closure materials under this Act or title I of the  
10 Patients’ Bill of Rights Act of 2005 and whose  
11 duties do not include making decisions on  
12 claims for benefits.

13           “(C) LIMITATION.—Subparagraph (A)  
14 does not apply in connection with any directed  
15 recordkeeper to the extent that the directed rec-  
16 ordkeeper fails to follow the specific instruction  
17 of the plan or the employer or other plan spon-  
18 sor.

19           “(7) CONSTRUCTION.—Nothing in this sub-  
20 section shall be construed as—

21           “(A) saving from preemption a cause of  
22 action under State law for the failure to provide  
23 a benefit for an item or service which is specifi-  
24 cally excluded under the group health plan in-  
25 volved, except to the extent that—

1 “(i) the application or interpretation  
 2 of the exclusion involves a determination  
 3 described in section 104(d)(2) of the Pa-  
 4 tients’ Bill of Rights Act of 2005, or

5 “(ii) the provision of the benefit for  
 6 the item or service is required under Fed-  
 7 eral law or under applicable State law con-  
 8 sistent with subsection (b)(2)(B);

9 “(B) preempting a State law which re-  
 10 quires an affidavit or certificate of merit in a  
 11 civil action;

12 “(C) affecting a cause of action or remedy  
 13 under State law in connection with the provi-  
 14 sion or arrangement of excepted benefits (as de-  
 15 fined in section 733(c)), other than those de-  
 16 scribed in section 733(c)(2)(A); or

17 “(D) affecting a cause of action under  
 18 State law other than a cause of action described  
 19 in paragraph (1)(A).

20 “(8) PURCHASE OF INSURANCE TO COVER LI-  
 21 ABILITY.—Nothing in section 410 shall be construed  
 22 to preclude the purchase by a group health plan of  
 23 insurance to cover any liability or losses arising  
 24 under a cause of action described in paragraph  
 25 (1)(A).

1           “(9) RELIEF FROM LIABILITY FOR EMPLOYER  
2           OR OTHER PLAN SPONSOR BY MEANS OF DES-  
3           IGNATED DECISIONMAKER.—

4           “(A) IN GENERAL.—Paragraph (1) shall  
5           not apply with respect to any cause of action  
6           described in paragraph (1)(A) under State law  
7           insofar as such cause of action provides for li-  
8           ability with respect to a participant or bene-  
9           ficiary of an employer or plan sponsor (or an  
10          employee of such employer or sponsor acting  
11          within the scope of employment), if with respect  
12          to the employer or plan sponsor there is (or is  
13          deemed under subparagraph (B) to be) a des-  
14          ignated decisionmaker that meets the require-  
15          ments of section 502(o)(1) with respect to such  
16          participant or beneficiary. Such paragraph (1)  
17          shall apply with respect to any cause of action  
18          described in paragraph (1)(A) under State law  
19          against the designated decisionmaker of such  
20          employer or other plan sponsor with respect to  
21          the participant or beneficiary.

22          “(B) AUTOMATIC DESIGNATION.—A health  
23          insurance issuer shall be deemed to be a des-  
24          ignated decisionmaker for purposes of subpara-  
25          graph (A) with respect to the participants and

beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

“(C) TREATMENT OF CERTAIN TRUST FUNDS.—For purposes of this paragraph, the terms ‘employer’ and ‘plan sponsor’, in connection 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.).

“(10) PREVIOUSLY PROVIDED SERVICES.—

“(A) IN GENERAL.—Except as provided in this paragraph, paragraph (1) shall not apply with respect to a cause of action where the denial involved relates to an item or service that has already been fully provided to the partici-



1           pant or beneficiary under the plan or coverage  
2           and the claim relates solely to the subsequent  
3           denial of payment for the provision of such item  
4           or service.

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

7                   “(i) exclude a cause of action from ex-  
8                   emption under paragraph (1) where the  
9                   nonpayment involved results in the partici-  
10                  pant or beneficiary being unable to receive  
11                  further items or services that are directly  
12                  related to the item or service involved in  
13                  the denial referred to in subparagraph (A)  
14                  or that are part of a continuing treatment  
15                  or series of procedures;

16                  “(ii) exclude a cause of action from  
17                  exemption under paragraph (1) relating to  
18                  quality of care; or

19                  “(iii) limit liability that otherwise  
20                  would arise from the provision of the item  
21                  or services or the performance of a medical  
22                  procedure.

23           “(11) EXEMPTION FROM PERSONAL LIABILITY  
24           FOR INDIVIDUAL MEMBERS OF BOARDS OF DIREC-

1       TORS, JOINT BOARDS OF TRUSTEES, ETC.—Any indi-  
2       vidual who is—

3               “(A) a member of a board of directors of  
4       an employer or plan sponsor; or

5               “(B) a member of an association, com-  
6       mittee, employee organization, joint board of  
7       trustees, or other similar group of representa-  
8       tives of the entities that are the plan sponsor  
9       of plan maintained by two or more employers  
10      and one or more employee organizations;

11      shall not be personally liable, by reason of the ex-  
12      emption of a cause of action from preemption under  
13      this subsection, for conduct that is within the scope  
14      of employment or of plan-related duties of the indi-  
15      viduals unless the individual acts in a fraudulent  
16      manner for personal enrichment.

17              “(12) CHOICE OF LAW.—A cause of action ex-  
18      empted from preemption under paragraph (1) shall  
19      be governed by the law (including choice of law  
20      rules) of the State in which the plaintiff resides.

21              “(13) LIMITATION ON ATTORNEYS’ FEES.—

22              “(A) IN GENERAL.—Notwithstanding any  
23      other provision of law, or any arrangement,  
24      agreement, or contract regarding an attorney’s  
25      fee, the amount of an attorney’s contingency fee

allowable for a cause of action exemption from preemption under paragraph (1) shall not exceed  $\frac{1}{3}$  of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

“(B) DETERMINATION BY COURT.—The last court in which the action was pending upon the final disposition, including all appeals, of the action may review the attorney's fee to ensure that the fee is a reasonable one.

“(C) NO PREEMPTION OF STATE LAW.—Subparagraph (A) shall not apply with respect to a cause of action that is brought in a State that has a law or framework of laws with respect to the amount of an attorney's contingency fee that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings such a cause of action.

“(e) RULES OF CONSTRUCTION RELATING TO HEALTH CARE.—Nothing in this title shall be construed as—

“(1) affecting any State law relating to the practice of medicine or the provision of, or the failure to provide, medical care, or affecting any action

1 (whether the liability is direct or vicarious) based  
2 upon such a State law,

3 “(2) superseding any State law permitted under  
4 section 152(b)(1)(A) of the Patients’ Bill of Rights  
5 Act of 2005, or

6 “(3) affecting any applicable State law with re-  
7 spect to limitations on monetary damages.

8 “(f) NO RIGHT OF ACTION FOR RECOVERY, INDEM-  
9 NITY, OR CONTRIBUTION BY ISSUERS AGAINST TREATING  
10 HEALTH CARE PROFESSIONALS AND TREATING HOS-  
11 PITALS.—In the case of any care provided, or any treat-  
12 ment decision made, by the treating health care profes-  
13 sional or the treating hospital of a participant or bene-  
14 ficiary under a group health plan which consists of medical  
15 care provided under such plan, any cause of action under  
16 State law against the treating health care professional or  
17 the treating hospital by the plan or a health insurance  
18 issuer providing health insurance coverage in connection  
19 with the plan for recovery, indemnity, or contribution in  
20 connection with such care (or any medically reviewable de-  
21 cision made in connection with such care) or such treat-  
22 ment decision is superseded.”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply to acts and omissions (from which

1 a cause of action arises) occurring on or after the applica-  
2 ble effective date under section 601.

3 **SEC. 403. COOPERATION BETWEEN FEDERAL AND STATE**  
4 **AUTHORITIES.**

5 (a) IN GENERAL.—Subpart C of part 7 of subtitle  
6 B of title I of the Employee Retirement Income Security  
7 Act of 1974 (29 U.S.C. 1191 et seq.) is amended by add-  
8 ing at the end the following new section:

9 **“SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE**  
10 **AUTHORITIES.**

11 “(a) AGREEMENT WITH STATES.—A State may  
12 enter into an agreement with the Secretary for the delega-  
13 tion to the State of some or all of the Secretary’s authority  
14 under this title to enforce the requirements applicable  
15 under title I of the Patients’ Bill of Rights Act of 2005  
16 with respect to health insurance coverage offered by a  
17 health insurance issuer and with respect to a group health  
18 plan that is a non-Federal governmental plan.

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

(b) CLERICAL AMENDMENT.—The table of contents of such Act is amended by inserting after the item relating to section 734 the following new item:

“Sec. 735. Cooperation between Federal and State authorities”.

**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.**

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

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

“Sec. 9813. Standard relating to patients’ bill of rights”; and

(2) by inserting after section 9812 the following:

**“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF  
RIGHTS.**

“A group health plan shall comply with the requirements of title I of the Patients’ Bill of Rights Act of 2005 (as in effect as of the date of the enactment of such Act), and such requirements 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”; and

9 (2) by inserting after section 9813 the fol-  
 10 lowing:

11 **“SEC. 9814. STANDARD RELATING TO WOMEN’S HEALTH**  
 12 **AND CANCER RIGHTS.**

13 “The provisions of section 713 of the Employee Re-  
 14 tirement Income Security Act of 1974 (as in effect as of  
 15 the date of the enactment of this section) shall apply to  
 16 group health plans as if included in this subchapter.”.

17 **Subtitle B—Health Care Coverage**  
 18 **Access Tax Incentives**

19 **SEC. 511. CREDIT FOR HEALTH INSURANCE EXPENSES OF**  
 20 **SMALL BUSINESSES.**

21 (a) IN GENERAL.—Subpart D of part IV of sub-  
 22 chapter A of chapter 1 of the Internal Revenue Code of  
 23 1986 (relating to business-related credits) is amended by  
 24 adding at the end the following:

1   **“SEC. 45J. SMALL BUSINESS HEALTH INSURANCE EX-**  
2                   **PENSES.**

3           “(a) GENERAL RULE.—For purposes of section 38,  
4 in the case of a small employer, the health insurance credit  
5 determined under this section for the taxable year is an  
6 amount equal to the applicable percentage of the expenses  
7 paid by the taxpayer during the taxable year for health  
8 insurance coverage for such year provided under a new  
9 health plan for employees of such employer.

10          “(b) APPLICABLE PERCENTAGE.—For purposes of  
11 subsection (a), the applicable percentage is—

12               “(1) in the case of insurance purchased as a  
13 member of a qualified health benefit purchasing coa-  
14 lition (as defined in section 9841), 30 percent, and

15               “(2) in the case of insurance not described in  
16 paragraph (1), 20 percent.

17          “(c) LIMITATIONS.—

18               “(1) PER EMPLOYEE DOLLAR LIMITATION.—  
19 The amount of expenses taken into account under  
20 subsection (a) with respect to any employee for any  
21 taxable year shall not exceed—

22                       “(A) \$2,000 in the case of self-only cov-  
23 erage, and

24                       “(B) \$5,000 in the case of family coverage.

25          In the case of an employee who is covered by a new  
26 health plan of the employer for only a portion of



1       such taxable year, the limitation under the preceding  
2       sentence shall be an amount which bears the same  
3       ratio to such limitation (determined without regard  
4       to this sentence) as such portion bears to the entire  
5       taxable year.

6           “(2) PERIOD OF COVERAGE.—Expenses may be  
7       taken into account under subsection (a) only with  
8       respect to coverage for the 4-year period beginning  
9       on the date the employer establishes a new health  
10      plan.

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

12           “(1) HEALTH INSURANCE COVERAGE.—The  
13      term ‘health insurance coverage’ has the meaning  
14      given such term by section 9832(b)(1).

15           “(2) NEW HEALTH PLAN.—

16           “(A) IN GENERAL.—The term ‘new health  
17      plan’ means any arrangement of the employer  
18      which provides health insurance coverage to em-  
19      ployees if—

20           “(i) such employer (and any prede-  
21      cessor employer) did not establish or main-  
22      tain such arrangement (or any similar ar-  
23      rangement) at any time during the 2 tax-  
24      able years ending prior to the taxable year

1 in which the credit under this section is  
2 first allowed, and

3 “(ii) such arrangement provides  
4 health insurance coverage to at least 70  
5 percent of the qualified employees of such  
6 employer.

7 “(B) QUALIFIED EMPLOYEE.—

8 “(i) IN GENERAL.—The term ‘quali-  
9 fied employee’ means any employee of an  
10 employer if the annual rate of such em-  
11 ployee’s compensation (as defined in sec-  
12 tion 414(s)) exceeds \$10,000.

13 “(ii) TREATMENT OF CERTAIN EM-  
14 PLOYEES.—The term ‘employee’ shall in-  
15 clude a leased employee within the mean-  
16 ing of section 414(n).

17 “(3) SMALL EMPLOYER.—The term ‘small em-  
18 ployer’ has the meaning given to such term by sec-  
19 tion 4980D(d)(2); except that only qualified employ-  
20 ees shall be taken into account.

21 “(e) SPECIAL RULES.—

22 “(1) CERTAIN RULES MADE APPLICABLE.—For  
23 purposes of this section, rules similar to the rules of  
24 section 52 shall apply.

1           “(2) AMOUNTS PAID UNDER SALARY REDUC-  
2           TION ARRANGEMENTS.—No amount paid or incurred  
3           pursuant to a salary reduction arrangement shall be  
4           taken into account under subsection (a).

5           “(f) TERMINATION.—This section shall not apply to  
6           expenses paid or incurred by an employer with respect to  
7           any arrangement established on or after January 1,  
8           2014.”.

9           (b) CREDIT TO BE PART OF GENERAL BUSINESS  
10          CREDIT.—Section 38(b) of such Code (relating to current  
11          year business credit) is amended by striking “plus” at the  
12          end of paragraph (18), by striking the period at the end  
13          of paragraph (19) and inserting “, plus”, and by adding  
14          at the end the following:

15                 “(20) in the case of a small employer (as de-  
16                 fined in section 45J(d)(3)), the health insurance  
17                 credit determined under section 45J(a).”.

18          (c) DENIAL OF DOUBLE BENEFIT.—Section 280C of  
19          such Code is amended by adding at the end the following  
20          new subsection:

21                 “(e) CREDIT FOR SMALL BUSINESS HEALTH INSUR-  
22          ANCE EXPENSES.—

23                 “(1) IN GENERAL.—No deduction shall be al-  
24                 lowed for that portion of the expenses (otherwise al-  
25                 lowable as a deduction) taken into account in deter-

1 mining the credit under section 45J for the taxable  
 2 year which is equal to the amount of the credit de-  
 3 termined for such taxable year under section 45J(a).

4 “(2) CONTROLLED GROUPS.—Persons treated  
 5 as a single employer under subsection (a) or (b) of  
 6 section 52 shall be treated as 1 person for purposes  
 7 of this section.”.

8 (d) CLERICAL AMENDMENT.—The table of sections  
 9 for subpart D of part IV of subchapter A of chapter 1  
 10 of such Code is amended by adding at the end the fol-  
 11 lowing:

“Sec. 45J. Small business health insurance expenses”.

12 (e) EFFECTIVE DATE.—The amendments made by  
 13 this section shall apply to amounts paid or incurred in tax-  
 14 able years beginning after December 31, 2006, for ar-  
 15 rangements established after the date of the enactment  
 16 of this Act.

17 **SEC. 512. CERTAIN GRANTS BY PRIVATE FOUNDATIONS TO**  
 18 **QUALIFIED HEALTH BENEFIT PURCHASING**  
 19 **COALITIONS.**

20 (a) IN GENERAL.—Section 4942 of the Internal Rev-  
 21 enue Code of 1986 (relating to taxes on failure to dis-  
 22 tribute income) is amended by adding at the end the fol-  
 23 lowing:

24 “(k) CERTAIN QUALIFIED HEALTH BENEFIT PUR-  
 25 CHASING COALITION DISTRIBUTIONS.—

1           “(1) IN GENERAL.—For purposes of subsection  
2           (g), sections 170, 501, 507, 509, and 2522, and this  
3           chapter, a qualified health benefit purchasing coalition  
4           distribution by a private foundation shall be  
5           considered to be a distribution for a charitable purpose.  
6           pose.

7           “(2) QUALIFIED HEALTH BENEFIT PUR-  
8           CHASING COALITION DISTRIBUTION.—For purposes  
9           of paragraph (1)—

10           “(A) IN GENERAL.—The term ‘qualified  
11           health benefit purchasing coalition distribution’  
12           means any amount paid or incurred by a private  
13           foundation to or on behalf of a qualified  
14           health benefit purchasing coalition (as defined  
15           in section 9841) for purposes of payment or reimbursement  
16           of amounts paid or incurred in  
17           connection with the establishment and maintenance  
18           of such coalition.

19           “(B) EXCLUSIONS.—Such term shall not  
20           include any amount used by a qualified health  
21           benefit purchasing coalition (as so defined)—

22                   “(i) for the purchase of real property,  
23                   “(ii) as payment to, or for the benefit  
24                   of, members (or employees or affiliates of  
25                   such members) of such coalition, or

1 “(iii) for any expense paid or incurred  
 2 more than 48 months after the date of es-  
 3 tablishment of such coalition.

4 “(3) TERMINATION.—This subsection shall not  
 5 apply—

6 “(A) to qualified health benefit purchasing  
 7 coalition distributions paid or incurred after  
 8 December 31, 2013, and

9 “(B) with respect to start-up costs of a co-  
 10 alition which are paid or incurred after Decem-  
 11 ber 31, 2014.”.

12 (b) QUALIFIED HEALTH BENEFIT PURCHASING CO-  
 13 ALITION.—

14 (1) IN GENERAL.—Chapter 100 of such Code  
 15 (relating to group health plan requirements) is  
 16 amended by adding at the end the following new  
 17 subchapter:

18 **“Subchapter D—Qualified Health Benefit**  
 19 **Purchasing Coalition**

“Sec. 9841. Qualified health benefit purchasing coalition

20 **“SEC. 9841. QUALIFIED HEALTH BENEFIT PURCHASING CO-**  
 21 **ALITION.**

22 “(a) IN GENERAL.—A qualified health benefit pur-  
 23 chasing coalition is a private not-for-profit corporation  
 24 which—

1           “(1) sells health insurance through State li-  
2           censed health insurance issuers in the State in which  
3           the employers to which such coalition is providing  
4           insurance are located, and

5           “(2) establishes to the Secretary, under State  
6           certification procedures or other procedures as the  
7           Secretary may provide by regulation, that such coali-  
8           tion meets the requirements of this section.

9           “(b) BOARD OF DIRECTORS.—

10           “(1) IN GENERAL.—Each purchasing coalition  
11           under this section shall be governed by a Board of  
12           Directors.

13           “(2) ELECTION.—The Secretary shall establish  
14           procedures governing election of such Board.

15           “(3) MEMBERSHIP.—The Board of Directors  
16           shall—

17           “(A) be composed of representatives of the  
18           members of the coalition, in equal number, in-  
19           cluding small employers and employee rep-  
20           resentatives of such employers, but

21           “(B) not include other interested parties,  
22           such as service providers, health insurers, or in-  
23           surance agents or brokers which may have a  
24           conflict of interest with the purposes of the coa-  
25           lition.

1 “(c) MEMBERSHIP OF COALITION.—

2 “(1) IN GENERAL.—A purchasing coalition  
3 shall accept all small employers residing within the  
4 area served by the coalition as members if such em-  
5 ployers request such membership.

6 “(2) OTHER MEMBERS.—The coalition, at the  
7 discretion of its Board of Directors, may be open to  
8 individuals and large employers.

9 “(3) VOTING.—Members of a purchasing coali-  
10 tion shall have voting rights consistent with the rules  
11 established by the State.

12 “(d) DUTIES OF PURCHASING COALITIONS.—Each  
13 purchasing coalition shall—

14 “(1) enter into agreements with small employ-  
15 ers (and, at the discretion of its Board, with individ-  
16 uals and other employers) to provide health insur-  
17 ance benefits to employees and retirees of such em-  
18 ployers,

19 “(2) where feasible, enter into agreements with  
20 3 or more unaffiliated, qualified licensed health  
21 plans, to offer benefits to members,

22 “(3) offer to members at least 1 open enroll-  
23 ment period of at least 30 days per calendar year,

24 “(4) serve a significant geographical area and  
25 market to all eligible members in that area, and



1           “(5) carry out other functions provided for  
2           under this section.

3           “(e) LIMITATION ON ACTIVITIES.—A purchasing coa-  
4           lition shall not—

5           “(1) perform any activity (including certifi-  
6           cation or enforcement) relating to compliance or li-  
7           censing of health plans,

8           “(2) assume insurance or financial risk in rela-  
9           tion to any health plan, or

10          “(3) perform other activities identified by the  
11          State as being inconsistent with the performance of  
12          its duties under this section.

13          “(f) ADDITIONAL REQUIREMENTS FOR PURCHASING  
14          COALITIONS.—As provided by the Secretary in regula-  
15          tions, a purchasing coalition shall be subject to require-  
16          ments similar to the requirements of a group health plan  
17          under this chapter.

18          “(g) RELATION TO OTHER LAWS.—

19          “(1) PREEMPTION OF STATE FICTITIOUS  
20          GROUP LAWS.—Requirements (commonly referred to  
21          as fictitious group laws) relating to grouping and  
22          similar requirements for health insurance coverage  
23          are preempted to the extent such requirements im-  
24          pede the establishment and operation of qualified  
25          health benefit purchasing coalitions.

1           “(2) ALLOWING SAVINGS TO BE PASSED  
 2           THROUGH.—Any State law that prohibits health in-  
 3           surance issuers from reducing premiums on health  
 4           insurance coverage sold through a qualified health  
 5           benefit purchasing coalition to reflect administrative  
 6           savings is preempted. This paragraph shall not be  
 7           construed to preempt State laws that impose restric-  
 8           tions on premiums based on health status, claims  
 9           history, industry, age, gender, or other underwriting  
 10          factors.

11          “(3) NO WAIVER OF HIPAA REQUIREMENTS.—  
 12          Nothing in this section shall be construed to change  
 13          the obligation of health insurance issuers to comply  
 14          with the requirements of title XXVII of the Public  
 15          Health Service Act with respect to health insurance  
 16          coverage offered to small employers in the small  
 17          group market through a qualified health benefit pur-  
 18          chasing coalition.

19          “(h) DEFINITION OF SMALL EMPLOYER.—For pur-  
 20          poses of this section—

21               “(1) IN GENERAL.—The term ‘small employer’  
 22               means, with respect to any calendar year, any em-  
 23               ployer if such employer employed an average of at  
 24               least 2 and not more than 50 qualified employees on  
 25               business days during either of the 2 preceding cal-

1       endar years. For purposes of the preceding sentence,  
 2       a preceding calendar year may be taken into account  
 3       only if the employer was in existence throughout  
 4       such year.

5               “(2) EMPLOYERS NOT IN EXISTENCE IN PRE-  
 6       CEDING YEAR.—In the case of an employer which  
 7       was not in existence throughout the 1st preceding  
 8       calendar year, the determination under paragraph  
 9       (1) shall be based on the average number of quali-  
 10      fied employees that it is reasonably expected such  
 11      employer will employ on business days in the current  
 12      calendar year.”.

13              (2) CONFORMING AMENDMENT.—The table of  
 14      subchapters for chapter 100 of such Code is amend-  
 15      ed by adding at the end the following item:

“SUBCHAPTER D—QUALIFIED HEALTH BENEFIT PURCHASING COALITION”.

16              (c) EFFECTIVE DATE.—The amendment made by  
 17      subsection (a) shall apply to taxable years beginning after  
 18      December 31, 2006.

19      **SEC. 513. STATE GRANT PROGRAM FOR MARKET INNOVA-**  
 20                                      **TION.**

21              (a) IN GENERAL.—The Secretary of Health and  
 22      Human Services (in this section referred to as the “Sec-  
 23      retary”) shall establish a program (in this section referred  
 24      to as the “program”) to award demonstration grants

1 under this section to States to allow States to demonstrate  
 2 the effectiveness of innovative ways to increase access to  
 3 health insurance through market reforms and other inno-  
 4 vative means. Such innovative means may include (and are  
 5 not limited to) any of the following:

6 (1) Alternative group purchasing or pooling ar-  
 7 rangements, such as purchasing cooperatives for  
 8 small businesses, reinsurance pools, or high risk  
 9 pools.

10 (2) Individual or small group market reforms.

11 (3) Consumer education and outreach.

12 (4) Subsidies to individuals, employers, or both,  
 13 in obtaining health insurance.

14 (b) SCOPE; DURATION.—The program shall be lim-  
 15 ited to not more than 10 States and to a total period of  
 16 5 years, beginning on the date the first demonstration  
 17 grant is made.

18 (c) CONDITIONS FOR DEMONSTRATION GRANTS.—

19 (1) IN GENERAL.—The Secretary may not pro-  
 20 vide for a demonstration grant to a State under the  
 21 program unless the Secretary finds that under the  
 22 proposed demonstration grant—

23 (A) the State will provide for demonstrated  
 24 increase of access for some portion of the exist-  
 25 ing uninsured population through a market in-

novation (other than merely through a financial expansion of a program initiated before the date of the enactment of this Act);

(B) the State will comply with applicable Federal laws;

(C) the State will not discriminate among participants on the basis of any health status-related factor (as defined in section 2791(d)(9) of the Public Health Service Act), except to the extent a State wishes to focus on populations that otherwise would not obtain health insurance because of such factors; and

(D) the State will provide for such evaluation, in coordination with the evaluation required under subsection (d), as the Secretary may specify.

(2) APPLICATION.—The Secretary shall not provide a demonstration grant under the program to a State unless—

(A) the State submits to the Secretary such an application, in such a form and manner, as the Secretary specifies;

(B) the application includes information regarding how the demonstration grant will address issues such as governance, targeted popu-

1           lation, expected cost, and the continuation after  
2           the completion of the demonstration grant pe-  
3           riod; and

4                   (C) the Secretary determines that the dem-  
5           onstration grant will be used consistent with  
6           this section.

7           (3) FOCUS.—A demonstration grant proposal  
8           under section need not cover all uninsured individ-  
9           uals in a State or all health care benefits with re-  
10          spect to such individuals.

11          (d) EVALUATION.—The Secretary shall enter into a  
12          contract with an appropriate entity outside the Depart-  
13          ment of Health and Human Services to conduct an overall  
14          evaluation of the program at the end of the program pe-  
15          riod. Such evaluation shall include an analysis of improve-  
16          ments in access, costs, quality of care, or choice of cov-  
17          erage, under different demonstration grants.

18          (e) OPTION TO PROVIDE FOR INITIAL PLANNING  
19          GRANTS.—Notwithstanding the previous provisions of this  
20          section, under the program the Secretary may provide for  
21          a portion of the amounts appropriated under subsection  
22          (f) (not to exceed \$5,000,000) to be made available to any  
23          State for initial planning grants to permit States to de-  
24          velop demonstration grant proposals under the previous  
25          provisions of this section.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There  
 2 are authorized to be appropriated \$100,000,000 for each  
 3 fiscal year to carry out this section. Amounts appropriated  
 4 under this subsection shall remain available until ex-  
 5 pended.

6 (g) STATE DEFINED.—For purposes of this section,  
 7 the term “State” has the meaning given such term for  
 8 purposes of title XIX of the Social Security Act.

9 **SEC. 514. GRANT PROGRAM TO FACILITATE HEALTH BENE-**  
 10 **FITS INFORMATION FOR SMALL EMPLOYERS.**

11 (a) IN GENERAL.—The Small Business Administra-  
 12 tion shall award grants to 1 or more States, local govern-  
 13 ments, and non-profit organizations for the purposes of—

14 (1) demonstrating new and effective ways to  
 15 provide information about the benefits of health in-  
 16 surance to small employers, including tax benefits,  
 17 increased productivity of employees, and decreased  
 18 turnover of employees,

19 (2) making employers aware of their current  
 20 rights in the marketplace under State and Federal  
 21 health insurance reforms, and

22 (3) making employers aware of the tax treat-  
 23 ment of insurance premiums.

24 (b) AUTHORIZATION.—There is authorized to be ap-  
 25 propriated \$10,000,000 for each of the first 5 fiscal years

1 beginning after the date of the enactment of this Act for  
2 grants under subsection (a).

3 **SEC. 515. STATE GRANT PROGRAM FOR MARKET INNOVA-**  
4 **TION.**

5 (a) IN GENERAL.—The Secretary of Health and  
6 Human Services (in this section referred to as the “Sec-  
7 retary”) shall establish a program (in this section referred  
8 to as the “program”) to award demonstration grants  
9 under this section to States to allow States to demonstrate  
10 the effectiveness of innovative ways to increase access to  
11 health insurance through market reforms and other inno-  
12 vative means. Such innovative means may include (and are  
13 not limited to) any of the following:

14 (1) Alternative group purchasing or pooling ar-  
15 rangements, such as purchasing cooperatives for  
16 small businesses, reinsurance pools, or high risk  
17 pools.

18 (2) Individual or small group market reforms.

19 (3) Consumer education and outreach.

20 (4) Subsidies to individuals, employers, or both,  
21 in obtaining health insurance.

22 (b) SCOPE; DURATION.—The program shall be lim-  
23 ited to not more than 10 States and to a total period of  
24 5 years, beginning on the date the first demonstration  
25 grant is made.



1 (c) CONDITIONS FOR DEMONSTRATION GRANTS.—

2 (1) IN GENERAL.—The Secretary may not pro-  
3 vide for a demonstration grant to a State under the  
4 program unless the Secretary finds that under the  
5 proposed demonstration grant—

6 (A) the State will provide for demonstrated  
7 increase of access for some portion of the exist-  
8 ing uninsured population through a market in-  
9 novation (other than merely through a financial  
10 expansion of a program initiated before the  
11 date of the enactment of this Act);

12 (B) the State will comply with applicable  
13 Federal laws;

14 (C) the State will not discriminate among  
15 participants on the basis of any health status-  
16 related factor (as defined in section 2791(d)(9)  
17 of the Public Health Service Act), except to the  
18 extent a State wishes to focus on populations  
19 that otherwise would not obtain health insur-  
20 ance because of such factors; and

21 (D) the State will provide for such evalua-  
22 tion, in coordination with the evaluation re-  
23 quired under subsection (d), as the Secretary  
24 may specify.

1           (2) APPLICATION.—The Secretary shall not  
2       provide a demonstration grant under the program to  
3       a State unless—

4           (A) the State submits to the Secretary  
5       such an application, in such a form and man-  
6       ner, as the Secretary specifies;

7           (B) the application includes information  
8       regarding how the demonstration grant will ad-  
9       dress issues such as governance, targeted popu-  
10      lation, expected cost, and the continuation after  
11      the completion of the demonstration grant pe-  
12      riod; and

13          (C) the Secretary determines that the dem-  
14      onstration grant will be used consistent with  
15      this section.

16          (3) FOCUS.—A demonstration grant proposal  
17      under section need not cover all uninsured individ-  
18      uals in a State or all health care benefits with re-  
19      spect to such individuals.

20          (d) EVALUATION.—The Secretary shall enter into a  
21      contract with an appropriate entity outside the Depart-  
22      ment of Health and Human Services to conduct an overall  
23      evaluation of the program at the end of the program pe-  
24      riod. Such evaluation shall include an analysis of improve-

1 ments in access, costs, quality of care, or choice of cov-  
 2 erage, under different demonstration grants.

3 (e) OPTION TO PROVIDE FOR INITIAL PLANNING  
 4 GRANTS.—Notwithstanding the previous provisions of this  
 5 section, under the program the Secretary may provide for  
 6 a portion of the amounts appropriated under subsection  
 7 (f) (not to exceed \$5,000,000) to be made available to any  
 8 State for initial planning grants to permit States to de-  
 9 velop demonstration grant proposals under the previous  
 10 provisions of this section.

11 (f) AUTHORIZATION OF APPROPRIATIONS.—There  
 12 are authorized to be appropriated \$100,000,000 for each  
 13 fiscal year to carry out this section. Amounts appropriated  
 14 under this subsection shall remain available until ex-  
 15 pended.

16 (g) STATE DEFINED.—For purposes of this section,  
 17 the term “State” has the meaning given such term for  
 18 purposes of title XIX of the Social Security Act.

19 **TITLE VI—EFFECTIVE DATES;**  
 20 **COORDINATION IN IMPLE-**  
 21 **MENTATION**

22 **SEC. 601. EFFECTIVE DATES.**

23 (a) GROUP HEALTH COVERAGE.—

24 (1) IN GENERAL.—Subject to paragraph (2)  
 25 and subsection (d), the amendments made by sec-

1 tions 201(a), 401, 501, and 502 (and title I insofar  
2 as it relates to such sections) shall apply with re-  
3 spect to group health plans, and health insurance  
4 coverage offered in connection with group health  
5 plans, for plan years beginning on or after October  
6 1, 2006 (in this section referred to as the “general  
7 effective date”).

8 (2) TREATMENT OF COLLECTIVE BARGAINING  
9 AGREEMENTS.—In the case of a group health plan  
10 maintained pursuant to one or more collective bar-  
11 gaining agreements between employee representa-  
12 tives and one or more employers ratified before the  
13 date of the enactment of this Act, the amendments  
14 made by sections 201(a), 401, 501, and 502 (and  
15 title I insofar as it relates to such sections) shall not  
16 apply to plan years beginning before the later of—

17 (A) the date on which the last collective  
18 bargaining agreements relating to the plan ter-  
19 minates (excluding any extension thereof agreed  
20 to after the date of the enactment of this Act);  
21 or

22 (B) the general effective date;

23 but shall apply not later than 1 year after the gen-  
24 eral effective date. For purposes of subparagraph  
25 (A), any plan amendment made pursuant to a collec-

1       tive bargaining agreement relating to the plan which  
 2       amends the plan solely to conform to any require-  
 3       ment added by this Act shall not be treated as a ter-  
 4       mination of such collective bargaining agreement.

5       (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—

6       Subject to subsection (d), the amendments made by sec-  
 7       tion 202 shall apply with respect to individual health in-  
 8       surance coverage offered, sold, issued, renewed, in effect,  
 9       or operated in the individual market on or after the gen-  
 10      eral effective date.

11      (c) TREATMENT OF RELIGIOUS NONMEDICAL PRO-  
 12      VIDERS.—

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

15           (A) restrict or limit the right of group  
 16      health plans, and of health insurance issuers of-  
 17      fering health insurance coverage, to include as  
 18      providers religious nonmedical providers;

19           (B) require such plans or issuers to—

20           (i) utilize medically based eligibility  
 21      standards or criteria in deciding provider  
 22      status of religious nonmedical providers;

23           (ii) use medical professionals or cri-  
 24      teria to decide patient access to religious  
 25      nonmedical providers;

1 (iii) utilize medical professionals or  
 2 criteria in making decisions in internal or  
 3 external appeals regarding coverage for  
 4 care by religious nonmedical providers; or

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

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

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

22 (d) TRANSITION FOR NOTICE REQUIREMENT.—The  
 23 disclosure of information required under section 121 of  
 24 this Act shall first be provided pursuant to—

1           (1) subsection (a) with respect to a group  
2       health plan that is maintained as of the general ef-  
3       fective date, not later than 30 days before the begin-  
4       ning of the first plan year to which title I applies  
5       in connection with the plan under such subsection;  
6       or

7           (2) subsection (b) with respect to an individual  
8       health insurance coverage that is in effect as of the  
9       general effective date, not later than 30 days before  
10      the first date as of which title I applies to the cov-  
11      erage under such subsection.

12 **SEC. 602. COORDINATION IN IMPLEMENTATION.**

13       The Secretary of Labor and the Secretary of Health  
14      and Human Services shall ensure, through the execution  
15      of an interagency memorandum of understanding among  
16      such Secretaries, that—

17           (1) regulations, rulings, and interpretations  
18      issued by such Secretaries relating to the same mat-  
19      ter over which such Secretaries have responsibility  
20      under the provisions of this Act (and the amend-  
21      ments made thereby) are administered so as to have  
22      the same effect at all times; and

23           (2) coordination of policies relating to enforcing  
24      the same requirements through such Secretaries in  
25      order to have a coordinated enforcement strategy

1       that avoids duplication of enforcement efforts and  
2       assigns priorities in enforcement.

3   **SEC. 603. SEVERABILITY.**

4       If any provision of this Act, an amendment made by  
5   this Act, or the application of such provision or amend-  
6   ment to any person or circumstance is held to be unconsti-  
7   tutional, the remainder of this Act, the amendments made  
8   by this Act, and the application of the provisions of such  
9   to any person or circumstance shall not be affected there-  
10  by.

11       **TITLE VII—MISCELLANEOUS**  
12               **PROVISIONS**

13   **SEC. 701. NO IMPACT ON SOCIAL SECURITY TRUST FUND.**

14       (a) IN GENERAL.—Nothing in this Act (or an amend-  
15   ment made by this Act) shall be construed to alter or  
16   amend the Social Security Act (or any regulation promul-  
17   gated under that Act).

18       (b) TRANSFERS.—

19           (1) ESTIMATE OF SECRETARY.—The Secretary  
20       of the Treasury shall annually estimate the impact  
21       that the enactment of this Act has on the income  
22       and balances of the trust funds established under  
23       section 201 of the Social Security Act (42 U.S.C.  
24       401).



1           (2) TRANSFER OF FUNDS.—If, under para-  
2       graph (1), the Secretary of the Treasury estimates  
3       that the enactment of this Act has a negative impact  
4       on the income and balances of the trust funds estab-  
5       lished under section 201 of the Social Security Act  
6       (42 U.S.C. 401), the Secretary shall transfer, not  
7       less frequently than quarterly, from the general reve-  
8       nues of the Federal Government an amount suffi-  
9       cient so as to ensure that the income and balances  
10      of such trust funds are not reduced as a result of  
11      the enactment of such Act.

○