

109TH CONGRESS
2D SESSION

S. 2551

To provide for prompt payment and interest on late payments of health care claims.

IN THE SENATE OF THE UNITED STATES

APRIL 5, 2006

Mr. MENENDEZ (for himself and Mr. LAUTENBERG) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide for prompt payment and interest on late payments of health care claims.

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.**

4 This Act may be cited as the “Prompt Payment of
5 Health Benefits Claims Act of 2006”.

6 **SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**
7 **COME SECURITY ACT OF 1974.**

8 (a) IN GENERAL.—Subpart B of part 7 of subtitle
9 B of title I of the Employee Retirement Income Security

1 Act of 1974 (29 U.S.C. 1185 et seq.) is amended by add-
2 ing at the end the following:

3 **“SEC. 714. PROMPT PAYMENT OF HEALTH BENEFITS**
4 **CLAIMS.**

5 “(a) TIMEFRAME FOR PAYMENT OF CLEAN CLAIM.—
6 A group health plan, and a health insurance issuer offer-
7 ing group health insurance coverage in connection with a
8 group health plan, shall pay all clean claims and
9 uncontested claims—

10 “(1) in the case of a claim that is submitted
11 electronically, within 14 days of the date on which
12 the claim is submitted; or

13 “(2) in the case of a claim that is not submitted
14 electronically, within 30 days of the date on which
15 the claim is submitted.

16 “(b) PROCEDURES INVOLVING SUBMITTED
17 CLAIMS.—

18 “(1) IN GENERAL.—Not later than 10 days
19 after the date on which a clean claim is submitted,
20 a group health plan, and a health insurance issuer
21 offering group health insurance coverage in connec-
22 tion with a group health plan, shall provide the
23 claimant with a notice that acknowledges receipt of
24 the claim by the plan or issuer. Such notice shall be
25 considered to have been provided on the date on

1 which the notice is mailed or electronically trans-
2 ferred.

3 “(2) CLAIM DEEMED TO BE CLEAN.—A claim is
4 deemed to be a clean claim under this section if the
5 group health plan or health insurance issuer involved
6 does not provide notice to the claimant of any defi-
7 ciency in the claim within 10 days of the date on
8 which the claim is submitted.

9 “(3) CLAIM DETERMINED TO NOT BE A CLEAN
10 CLAIM.—

11 “(A) IN GENERAL.—If a group health plan
12 or health insurance issuer determines that a
13 claim for health care expenses is not a clean
14 claim, the plan or issuer shall, not later than
15 the end of the period described in paragraph
16 (2), notify the claimant of such determination.
17 Such notification shall specify all deficiencies in
18 the claim and shall list with specificity all addi-
19 tional information or documents necessary for
20 the proper processing and payment of the
21 claim.

22 “(B) DETERMINATION AFTER SUBMISSION
23 OF ADDITIONAL INFORMATION.—A claim is
24 deemed to be a clean claim under this para-
25 graph if the group health plan or health insur-

1 ance issuer involved does not provide notice to
2 the claimant of any deficiency in the claim with-
3 in 10 days of the date on which additional in-
4 formation is received pursuant to subparagraph
5 (A).

6 “(C) PAYMENT OF UNCONTESTED POR-
7 TION OF A CLAIM.—A group health plan or
8 health insurance issuer shall pay any
9 uncontested portion of a claim in accordance
10 with subsection (a).

11 “(4) OBLIGATION TO PAY.—A claim for health
12 care expenses that is not paid or contested by a
13 group health plan or health insurance issuer within
14 the timeframes set forth in this subsection shall be
15 deemed to be a clean claim and paid by the plan or
16 issuer in accordance with subsection (a).

17 “(c) DATE OF PAYMENT OF CLAIM.—Payment of a
18 clean claim under this section is considered to have been
19 made on the date on which full payment is received by
20 the health care provider.

21 “(d) INTEREST SCHEDULE.—

22 “(1) IN GENERAL.—With respect to a clean
23 claim, a group health plan or health insurance issuer
24 that fails to comply with subsection (a) shall pay the
25 claimant interest on the amount of such claim, from

1 the date on which such payment was due as provided
2 in this section, at the following rates:

3 “(A) 1½ percent per month from the 1st
4 day of nonpayment after payment is due
5 through the 15th day of such nonpayment.

6 “(B) 2 percent per month from the 16th
7 day of such nonpayment through the 45th day
8 of such nonpayment.

9 “(C) 2½ percent per month after the 46th
10 day of such nonpayment.

11 “(2) CONTESTED CLAIMS.—With respect to
12 claims for health care expenses that are contested by
13 the plan or issuer, once such claim is deemed clean
14 under subsection (b), the interest rate applicable for
15 noncompliance under this subsection shall apply con-
16 sistent with paragraph (1).

17 “(e) PRIVATE RIGHT OF ACTION.—Nothing in this
18 section shall be construed to prohibit or limit a claim or
19 action not covered by the subject matter of this section
20 that any claimant has against a group health plan, or a
21 health insurance issuer.

22 “(f) ANTI-RETALIATION.—Consistent with applicable
23 Federal or State law, a group health plan or health insur-
24 ance issuer shall not retaliate against a claimant for exer-
25 cising a right of action under this section.

1 “(g) FINES AND PENALTIES.—

2 “(1) FINES.—

3 “(A) IN GENERAL.—If a group health
4 plan, or health insurance issuer offering group
5 health insurance coverage, willfully and know-
6 ingly violates this section or has a pattern of re-
7 peated violations of this section, the Secretary
8 shall impose a fine not to exceed \$1,000 per
9 claim for each day a response is delinquent be-
10 yond the date on which such response is re-
11 quired under this section.

12 “(B) REPEATED VIOLATIONS.—If 3 sepa-
13 rate fines under subparagraph (A) are levied
14 within a 5-year period, the Secretary is author-
15 ized to impose a penalty in an amount not to
16 exceed \$10,000 per claim.

17 “(2) REMEDIAL ACTION PLAN.—Where it is es-
18 tablished that the group health plan or health insur-
19 ance issuer willfully and knowingly violated this sec-
20 tion or has a pattern of repeated violations, the Sec-
21 retary shall require the group health plan or health
22 insurance issuer to—

23 “(A) submit a remedial action plan to the
24 Secretary; and

1 “(B) contact claimants regarding the
 2 delays in the processing of claims and inform
 3 claimants of steps being taken to improve such
 4 delays.

5 “(h) DEFINITIONS.—In this section:

6 “(1) CLAIMANT.—The term ‘claimant’ means a
 7 participant, beneficiary, pharmacy, or health care
 8 provider submitting a claim for payment of health
 9 care expenses.

10 “(2) CLEAN CLAIM.—The term ‘clean claim’
 11 means a claim—

12 “(A) with respect to health care expenses
 13 for an individual who is covered under a group
 14 health plan on the date such expenses are in-
 15 curred;

16 “(B) for such expenses that are covered
 17 under such plan at such time; and

18 “(C) that is submitted with all of the infor-
 19 mation requested by a group health plan or
 20 health insurance issuer offering group health
 21 insurance coverage in connection with a group
 22 health plan on the claim form or other instruc-
 23 tions provided to the health care provider prior
 24 to submission of the claim.

1 “(3) CONTESTED CLAIM.—The term ‘contested
2 claim’ means a claim for health care expenses that
3 is denied by a group health plan or health insurance
4 issuer during or after the benefit determination
5 process.

6 “(4) HEALTH CARE PROVIDER.—The term
7 ‘health care provider’ includes a physician or other
8 individual who is licensed, accredited, or certified
9 under State law to provide specified health care
10 services and who is operating within the scope of
11 such licensure, accreditation, or certification, as well
12 as an institution or other facility or agency that pro-
13 vides health care services and is licensed, accredited,
14 or certified to provide health care items and services
15 under applicable State law.”.

16 **SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
17 **ACT.**

18 (a) GROUP MARKET.—Subpart 2 of part A of title
19 XXVII of the Public Health Service Act (42 U.S.C.
20 300gg–4 et seq.) is amended by adding at the end the
21 following:

22 **“SEC. 2707. PROMPT PAYMENT OF HEALTH BENEFITS**
23 **CLAIMS.**

24 “(a) TIMEFRAME FOR PAYMENT OF CLEAN CLAIM.—
25 A group health plan, and a health insurance issuer offer-

1 ing group health insurance coverage in connection with a
 2 group health plan, shall pay all clean claims and
 3 uncontested claims—

4 “(1) in the case of a claim that is submitted
 5 electronically, within 14 days of the date on which
 6 the claim is submitted; or

7 “(2) in the case of a claim that is not submitted
 8 electronically, within 30 days of the date on which
 9 the claim is submitted.

10 “(b) PROCEDURES INVOLVING SUBMITTED
 11 CLAIMS.—

12 “(1) IN GENERAL.—Not later than 10 days
 13 after the date on which a clean claim is submitted,
 14 a group health plan, and a health insurance issuer
 15 offering group health insurance coverage in connec-
 16 tion with a group health plan, shall provide the
 17 claimant with a notice that acknowledges receipt of
 18 the claim by the plan or issuer. Such notice shall be
 19 considered to have been provided on the date on
 20 which the notice is mailed or electronically trans-
 21 ferred.

22 “(2) CLAIM DEEMED TO BE A CLEAN CLAIM.—
 23 A claim is deemed to be a clean claim under this
 24 section if the group health plan or health insurance
 25 issuer involved does not provide notice to the claim-

1 ant of any deficiency in the claim within 10 days of
2 the date on which the claim is submitted.

3 “(3) CLAIM DETERMINED TO NOT BE A CLEAN
4 CLAIM.—

5 “(A) IN GENERAL.—If a group health plan
6 or health insurance issuer determines that a
7 claim for health care expenses is not clean, the
8 plan or issuer shall, not later than the end of
9 the period described in paragraph (2), notify
10 the claimant of such determination. Such notifi-
11 cation shall specify all deficiencies in the claim
12 and shall list with specificity all additional in-
13 formation or documents necessary for the prop-
14 er processing and payment of the claim.

15 “(B) DETERMINATION AFTER SUBMISSION
16 OF ADDITIONAL INFORMATION.—A claim is
17 deemed to be a clean claim under this para-
18 graph if the group health plan or health insur-
19 ance issuer involved does not provide notice to
20 the claimant of any deficiency in the claim with-
21 in 10 days of the date on which the additional
22 information is received pursuant to subpara-
23 graph (A).

24 “(C) PAYMENT OF UNCONTESTED POR-
25 TION OF A CLAIM.—A group health plan or

1 health insurance issuer shall pay any
2 uncontested portion of a claim in accordance
3 with subsection (a).

4 “(4) OBLIGATION TO PAY.—A claim for health
5 care expenses that is not paid or contested by a
6 group health plan or health insurance issuer within
7 the timeframes set forth in this subsection shall be
8 deemed to be a clean claim and paid by the plan or
9 issuer in accordance with subsection (a).

10 “(c) DATE OF PAYMENT OF CLAIM.—Payment of a
11 clean claim under this section is considered to have been
12 made on the date on which full payment is received by
13 the health care provider.

14 “(d) INTEREST SCHEDULE.—

15 “(1) IN GENERAL.—With respect to a clean
16 claim, a group health plan or health insurance issuer
17 that fails to comply with subsection (a) shall pay the
18 claimant interest on the amount of such claim, from
19 the date on which such payment was due as provided
20 in this section, at the following rates:

21 “(A) 1½ percent per month from the 1st
22 day of nonpayment after payment is due
23 through the 15th day of such nonpayment.

1 “(B) 2 percent per month from the 16th
2 day of such nonpayment through the 45th day
3 of such nonpayment.

4 “(C) 2½ percent per month after the 46th
5 day of such nonpayment.

6 “(2) CONTESTED CLAIMS.—With respect to
7 claims for health care expenses that are contested by
8 the plan or issuer, once such claim is deemed clean
9 under subsection (b), the interest rate applicable for
10 noncompliance under this subsection shall apply con-
11 sistent with paragraph (1).

12 “(e) PRIVATE RIGHT OF ACTION.—Nothing in this
13 section shall be construed to prohibit or limit a claim or
14 action not covered by the subject matter of this section
15 that any claimant has against a group health plan, or a
16 health insurance issuer.

17 “(f) ANTI-RETALIATION.—Consistent with applicable
18 Federal or State law, a group health plan or health insur-
19 ance issuer shall not retaliate against a claimant for exer-
20 cising a right of action under this section.

21 “(g) FINES AND PENALTIES.—

22 “(1) FINES.—

23 “(A) IN GENERAL.—If a group health
24 plan, or health insurance issuer offering group
25 health insurance coverage, willfully and know-

1 ingly violates this section or has a pattern of re-
 2 peated violations of this section, the Secretary
 3 shall impose a fine not to exceed \$1,000 per
 4 claim for each day a response is delinquent be-
 5 yond the date on which such response is re-
 6 quired under this section.

7 “(B) REPEATED VIOLATIONS.—If 3 sepa-
 8 rate fines under subparagraph (A) are levied
 9 within a 5-year period, the Secretary is author-
 10 ized to impose a penalty in an amount not to
 11 exceed \$10,000 per claim.

12 “(2) REMEDIAL ACTION PLAN.—Where it is es-
 13 tablished that the group health plan or health insur-
 14 ance issuer willfully and knowingly violated this sec-
 15 tion or has a pattern of repeated violations, the Sec-
 16 retary shall require the health plan or health insur-
 17 ance issuer to—

18 “(A) submit a remedial action plan to the
 19 Secretary; and

20 “(B) contact claimants regarding the
 21 delays in the processing of claims and inform
 22 claimants of steps being taken to improve such
 23 delays.

24 “(h) DEFINITIONS.—In this section:

1 “(1) CLAIMANT.—The term ‘claimant’ means a
2 participant, beneficiary, pharmacy, or health care
3 provider submitting a claim for payment of health
4 care expenses.

5 “(2) CLEAN CLAIM.—The term ‘clean claim’
6 means a claim—

7 “(A) with respect to health care expenses
8 for an individual who is covered under a group
9 health plan on the date such expenses are in-
10 curred;

11 “(B) for such expenses that are covered
12 under such plan at such time; and

13 “(C) that is submitted with all of the infor-
14 mation requested by a group health plan or
15 health insurance issuer offering group health
16 insurance coverage in connection with a group
17 health plan on the claim form or other instruc-
18 tions provided to the health care provider prior
19 to submission of the claim.

20 “(3) CONTESTED CLAIM.—The term ‘contested
21 claim’ means a claim for health care expenses that
22 is denied by a group health plan or health insurance
23 issuer during or after the benefit determination
24 process.

1 “(4) HEALTH CARE PROVIDER.—The term
 2 ‘health care provider’ includes a physician or other
 3 individual who is licensed, accredited, or certified
 4 under State law to provide specified health care
 5 services and who is operating within the scope of
 6 such licensure, accreditation, or certification, as well
 7 as an institution or other facility or agency that pro-
 8 vides health care services and is licensed, accredited,
 9 or certified to provide health care items and services
 10 under applicable State law.”.

11 (b) INDIVIDUAL MARKET.—Part B of title XXVII of
 12 the Public Health Service Act (42 U.S.C. 300gg–41 et
 13 seq.) is amended—

14 (1) by redesignating the first subpart 3 (relat-
 15 ing to other requirements) as subpart 2; and

16 (2) by adding at the end of subpart 2 the fol-
 17 lowing:

18 **“SEC. 2753. STANDARDS RELATING TO PROMPT PAYMENT**
 19 **OF HEALTH BENEFITS CLAIMS.**

20 “The provisions of section 2707 shall apply to health
 21 insurance coverage offered by a health insurance issuer
 22 in the individual market in the same manner as they apply
 23 to health insurance coverage offered by a health insurance
 24 issuer in connection with a group health plan in the small
 25 or large group market.”.

1 **SEC. 4. AMENDMENTS TO THE SOCIAL SECURITY ACT.**

2 (a) PROMPT PAYMENT BY PRESCRIPTION DRUG
 3 PLANS.—Section 1860D–12(b) of the Social Security Act
 4 (42 U.S.C. 1395w–112(b)) is amended by adding at the
 5 end the following new paragraph:

6 “(4) PROMPT PAYMENT OF CLEAN CLAIMS.—

7 “(A) PROMPT PAYMENT.—

8 “(i) IN GENERAL.—Each contract en-
 9 tered into with a PDP sponsor under this
 10 section with respect to a prescription drug
 11 plan offered by such sponsor shall provide
 12 that payment shall be issued, mailed, or
 13 otherwise transmitted with respect to all
 14 clean claims submitted under this part
 15 within the applicable number of calendar
 16 days after the date on which the claim is
 17 received.

18 “(ii) CLEAN CLAIM DEFINED.—In this
 19 paragraph, the term ‘clean claim’ means a
 20 claim—

21 “(I) with respect to health care
 22 expenses for an individual who is cov-
 23 ered under a group health plan on the
 24 date such expenses are incurred;

1 “(II) for such expenses that are
 2 covered under such plan at such time;
 3 and

4 “(III) that is submitted with all
 5 of the information requested by a
 6 group health plan or health insurance
 7 issuer offering group health insurance
 8 coverage in connection with a group
 9 health plan on the claim form or other
 10 instructions provided to the health
 11 care provider prior to submission of
 12 the claim.

13 “(B) APPLICABLE NUMBER OF CALENDAR
 14 DAYS DEFINED.—In this paragraph, the term
 15 ‘applicable number of calendar days’ means—

16 “(i) with respect to claims submitted
 17 electronically, 14 days; and

18 “(ii) with respect to claims submitted
 19 otherwise, 30 days.

20 “(C) INTEREST SCHEDULE.—

21 “(i) IN GENERAL.—With respect to a
 22 clean claim, a PDP sponsor that fails to
 23 comply with subparagraph (A) shall pay
 24 the claimant interest on the amount of
 25 such claim, from the date on which such

1 payment was due as provided in this para-
2 graph, at the following rates:

3 “(I) 1½ percent per month from
4 the 1st day of nonpayment after pay-
5 ment is due through the 15th day of
6 such nonpayment.

7 “(II) 2 percent per month from
8 the 16th day of such nonpayment
9 through the 45th day of such non-
10 payment.

11 “(III) 2½ percent per month
12 after the 46th day of such non-
13 payment.

14 “(D) PROCEDURES INVOLVING CLAIMS.—

15 “(i) IN GENERAL.—A contract entered
16 into with a PDP sponsor under this sec-
17 tion with respect to a prescription drug
18 plan offered by such sponsor shall provide
19 that, not later than 10 days after the date
20 on which a clean claim is submitted, the
21 PDP sponsor shall provide the claimant
22 with a notice that acknowledges receipt of
23 the claim by such sponsor. Such notice
24 shall be considered to have been provided

1 on the date on which the notice is mailed
2 or electronically transferred.

3 “(ii) CLAIM DEEMED TO BE A CLEAN
4 CLAIM.—A claim is deemed to be a clean
5 claim if the PDP sponsor involved does not
6 provide notice to the claimant of any defi-
7 ciency in the claim within 10 days of the
8 date on which the claim is submitted.

9 “(iii) CLAIM DETERMINED TO NOT BE
10 A CLEAN CLAIM.—

11 “(I) IN GENERAL.—If a PDP
12 sponsor determines that a submitted
13 claim is not a clean claim, the PDP
14 sponsor shall, not later than the end
15 of the period described in clause (ii),
16 notify the claimant of such determina-
17 tion. Such notification shall specify all
18 defects or improprieties in the claim
19 and shall list with specificity all addi-
20 tional information or documents nec-
21 essary for the proper processing and
22 payment of the claim.

23 “(II) DETERMINATION AFTER
24 SUBMISSION OF ADDITIONAL INFOR-
25 MATION.—A claim is deemed to be a

1 clean claim under this paragraph if
2 the PDP sponsor involved does not
3 provide notice to the claimant of any
4 defect or impropriety in the claim
5 within 10 days of the date on which
6 additional information is received
7 under subclause (I).

8 “(III) PAYMENT OF CLEAN POR-
9 TION OF A CLAIM.—A PDP sponsor
10 shall, as appropriate, pay any portion
11 of a claim that would be a clean claim
12 but for a defect or impropriety in a
13 separate portion of the claim in ac-
14 cordance with subparagraph (A).

15 “(iv) OBLIGATION TO PAY.—A claim
16 submitted to a PDP sponsor that is not
17 paid or contested by the provider within
18 the applicable number of days (as defined
19 in subparagraph (B)) shall be deemed to
20 be a clean claim and shall be paid by the
21 PDP sponsor in accordance with subpara-
22 graph (A).

23 “(v) DATE OF PAYMENT OF CLAIM.—
24 Payment of a clean claim under such sub-
25 paragraph is considered to have been made

1 on the date on which full payment is re-
2 ceived by the provider.

3 “(E) PRIVATE RIGHT OF ACTION.—

4 “(i) IN GENERAL.—Nothing in this
5 paragraph shall be construed to prohibit or
6 limit a claim or action not covered by the
7 subject matter of this section that any in-
8 dividual or organization has against a pro-
9 vider or a PDP sponsor.

10 “(ii) ANTI-RETALIATION.—Consistent
11 with applicable Federal or State law, a
12 PDP sponsor shall not retaliate against an
13 individual or provider for exercising a right
14 of action under this subparagraph.

15 “(F) FINES AND PENALTIES.—

16 “(i) FINES.—

17 “(I) IN GENERAL.—If a PDP
18 sponsor willfully and knowingly vio-
19 lates this section or has a pattern of
20 repeated violations of this section, the
21 Secretary shall impose a fine not to
22 exceed \$1,000 per claim for each day
23 a response is delinquent beyond the
24 date on which such response is re-
25 quired under this paragraph.

1 “(II) REPEATED VIOLATIONS.—

2 If 3 separate fines under subclause (I)
3 are levied within a 5-year period, the
4 Secretary is authorized to impose a
5 penalty in an amount not to exceed
6 \$10,000 per claim.

7 “(ii) REMEDIAL ACTION PLAN.—

8 Where it is established that the PDP spon-
9 sor willfully and knowingly violated this
10 section or has a pattern of repeated viola-
11 tions, the Secretary shall require the PDP
12 sponsor to—

13 “(I) submit a remedial action
14 plan to the Secretary; and

15 “(II) contact claimants regarding
16 the delays in the processing of claims
17 and inform claimants of steps being
18 taken to improve such delays.”.

19 (b) PROMPT PAYMENT BY MA-PD PLANS.—Section
20 1857(f) of the Social Security Act (42 U.S.C. 1395w-27)
21 is amended by adding at the end the following new para-
22 graph:

23 “(3) INCORPORATION OF CERTAIN PRESCRIP-
24 TION DRUG PLAN CONTRACT REQUIREMENTS.—The
25 provisions of section 1860D-12(b)(4) shall apply to

1 contracts with a Medicare Advantage organization in
 2 the same manner as they apply to contracts with a
 3 PDP sponsor offering a prescription drug plan
 4 under part D.”.

5 (c) MEDICAID.—Section 1932(f) of the Social Secu-
 6 rity Act (42 U.S.C. 1396u–2(f)) is amended by striking
 7 “the claims payment procedures described in section
 8 1902(a)(37)(A), unless the health care provider and the
 9 organization agree to an alternate payment schedule” and
 10 inserting “section 1860D–12(b)(4), in the same manner
 11 as the provisions of such section apply to a PDP sponsor
 12 offering a prescription drug plan under part D”.

13 (d) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply to contracts entered into or re-
 15 newed on or after December 31, 2006.

16 **SEC. 5. PREEMPTION.**

17 The provisions of this Act shall not supersede any
 18 contrary provision of State law if the provision of State
 19 law imposes requirements, standards, or implementation
 20 specifications that are equal to or more stringent than the
 21 requirements, standards, or implementation specifications
 22 imposed under this Act, and any such requirements,
 23 standards, or implementation specifications under State
 24 law that are equal to or more stringent than the require-
 25 ments, standards, or implementation specifications under

1 this Act shall apply to group health plans and health in-
2 surance issuers as provided for under State law.

3 **SEC. 6. EFFECTIVE DATE.**

4 (a) IN GENERAL.—Except as provided in section 4
5 and subsection (b), the amendments made by this Act
6 shall apply with respect to group health plans and health
7 insurance issuers for plan years beginning after December
8 31, 2006.

9 (b) SPECIAL RULE FOR COLLECTIVE BARGAINING
10 AGREEMENTS.—In the case of a group health plan main-
11 tained pursuant to one or more collective bargaining
12 agreements between employee representatives and one or
13 more employers ratified before the date of the enactment
14 of this Act, the amendments made by this Act shall not
15 apply to plan years beginning before the later of—

16 (1) the date on which the last of the collective
17 bargaining agreements relating to the plan termi-
18 nates (determined without regard to any extension
19 thereof agreed to after the date of the enactment of
20 this Act), or

21 (2) January 1, 2007.

22 For purposes of paragraph (1), any plan amendment made
23 pursuant to a collective bargaining agreement relating to
24 the plan which amends the plan solely to conform to any
25 requirement of the amendments made by this section shall

1 not be treated as a termination of such collective bar-
2 gaining agreement.

3 **SEC. 7. SEVERABILITY.**

4 If any provision of this Act, or an amendment made
5 by this Act, is held by a court to be invalid, such invalidity
6 shall not affect the remaining provisions of this Act, or
7 amendments made by this Act.

○