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BIPARTISAN PATIENT PROTECTION ACT

(Continued)

Who are jurors? Jurors are our neighbors, our voters. They are the American people. Trust them. When it comes to understanding what it costs to be deprived of a full and healthy life, jurors know what it means. They have more wisdom than lawyers, than doctors, and I dare say than Members of Congress.

Mr. STARK. Mr. Chairman, I yield 30 seconds to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Chairman, I was listening to my colleagues on the other side of the aisle talk about what this bill does. The Ganske-Dingell bill provides real patient protection, whether it is access to emergency care, specialists, whether it is primary care.

The Norwood amendment takes away those rights because there is no enforcement. There is no reason why HMOs will provide these particular protections. It is the opponents of the Ganske-Dingell bill that are telling Members that this Norwood amendment will perfect it.

What it does is take away the protections in the underlying bill. We should reject the Norwood amendment.

Mr. STARK. Mr. Chairman, I yield 45 seconds to the gentleman from Wisconsin (Mr. KIND).

(Mr. KIND asked and was given permission to revise and extend his remarks.)

Mr. KIND. Mr. Chairman, the debate today is not about the technicalities of a complicated piece of legislation: who has the rebuttal presumption, what the standard of care should be, whether patients are going to be suing in Federal court for this issue or State court for that.

This issue boils down to one simple proposition. If someone is in the business of making medical decisions that affect the health, welfare and lives of patients, that individual should be held to the same standard of responsibility as anyone else involved in that process, period. No exceptions. No carve-outs. No special treatments based on political contributions made in this place. That is what is at stake at the end of today's debate.

Mr. Chairman, I urge my colleagues to reject the Norwood special treatment amendment and instead pass a fair Patients' Bill of Rights.

Mr. STARK. Mr. Chairman, I yield 30 seconds to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, here is what two law professors from New Jersey say:

''In preempting State law, the Norwood amendment goes beyond conduct that involves negligent medical judgment to a particular patient's case. The amendment may, by virtue of the words 'based on,' stipulate that State malpractice law does not apply to any treatment decision made by a managed care organization, whether it be negligent, reckless, willful or wanton.

''For example, no State cause of action can be maintained against a designated decision-maker for his decision to discharge a patient early from a hospital even if the likely result of that discharge would be the patient's death. In short, all forms of vicarious liability under State law would be preempted under the Norwood amendment.''

Mr. STARK. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I will conclude by saying that we are in a sad state of affairs when we have dentists writing law and lawyers practicing medicine, and Congressmen trying to run HMOs. I have a list of 704 organizations that support the original Ganske-Dingell bill without the poison pill amendments.

There is not a health care professional organization in this country that does not support this bill, and the dental organization of the gentleman from Georgia (Mr. NORWOOD) supports the original bill. Why should we vote against those people that give us medical care? Do we know better? Is there somebody in this audience who would tell me of any medical profession that does not support the original bill and oppose the Norwood amendment?

If we are going to legislate to protect patients, let us make sure that we do it right and support the original Ganske-Dingell bill.

Mr. BOEHNER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the Ganske-Dingell bill would subject employers and unions, including many small businesses that voluntarily provide health benefits to their employees, to new lawsuits with unlimited damages and no protection from frivolous lawsuits.

I think it is pretty clear that Americans want a Patients' Bill of Rights. I think they have made it very clear, as well, that they do not want unlimited lawsuits. Expanding liability for small employers and unions who voluntarily offer health plans is wrong-headed and dangerous, and in my view, will cause millions of Americans to lose their coverage.

Mr. Chairman, all of us who serve in this body come from different walks of life. We have doctors that serve in the House. They happen to be split on both sides of this particular issue. We have our share of lawyers that occupy this body as our colleagues, and we have lawyers on both sides of this particular issue.

In my own case, I come to the halls of Congress as a small business person, someone who has in fact hired people, someone who has had to run a business, and someone who offered a health plan to my employees. I can tell my colleagues, as I have said year after year, debate after debate on this particular subject that if the underlying bill were

to pass as is and to become law, immediately I, as an employer, would eliminate the health benefits for my employees. Why? Because I would be subject to more increased litigation.

Every employer in America, and most of their employees as well, understand all of the litigation that is occurring in this country is causing prices to go up, and in many cases, causing businesses to go out of business.

One little lawsuit under that underlying bill that would be allowed could put under many, many small employers. Today, when new employers are the lifeblood of our economy, why would we want to increase the liability that we put on them?

Mr. Chairman, I think that we need to find a balanced approach, and I think the President, working with the gentleman from Georgia (Mr. NORWOOD), deserves an enormous amount of credit from all of us. The President put his prestige out on the line. He worked hard to come to some compromise that he would be willing to sign into law.

I am a little surprised at my colleagues across the aisle who have rejected the hand of the President over the last 6 months, and then today continue to reject the idea of trying to find some common ground and moving ahead.

What do they want to do? Do what we have done for the last 6 years, and we are going to get the same result. Nothing. I think the President deserves an awful lot of credit for ending the legislative gridlock on this issue. What do we have to fear? Nothing, because we are going to go to conference with the Senate which has a different bill. We have an opportunity to try to resolve the differences between the two bodies. That is the nature of our institution.

What we ought to do today is get behind the compromise bill that is going to be before us, support the Norwood amendment, support the bill on final passage, and let us work out our differences with the Senate. As we do, not only will Congress be winners, but more importantly, the American people will be great winners because they will have better access to health care, more patient protections; and regardless of which version of liability becomes law, they will have greater remedies in the law than they have today.

Even the amendment of the gentleman from Georgia (Mr. NORWOOD), which is being criticized here as being inadequate, goes far beyond what we have in law today. If Members want to help patients, why not accept his amendment? Give patients additional remedies and help them get the kind of quality health care that the American people want.

Ms. SOLIS. Mr. Chairman, this body has a chance to enact a real patient's bill of rights to protect people from the harmful decisions made by their health insurance plans.

All of us have heard from constituents who are fed up at being told by their health plans that they can't have access to the health care they need even through they pay their insurance premiums for this care in the first place!

So you would think all of us could agree that it's time to do something.

Instead, my Republican colleagues want to pass a bill that does nothing.

In fact, the bill supported by President Bush would roll back important patient protections already in place in my home state of California.

In California, we enacted a law that says to consumers—if your health plan interferes with the quality of the medical care you receive, you have a legal right to stop them through the courts.

If you are injured because your health insurance company delays or refuses you health care—you have a legal right to sue them through the courts.

It's just that simple.

But President Bush wants to take away my constituents' right to have protection from the bad decisions of their health insurance companies.

And he wants to call that managed care reform, I call it an HMO Protection Bill.

Well that's not right.

I urge my colleagues to reject any attempt to weaken the patient's bill of rights and to support real reform of health insurance companies.

Mrs. MCCARTHY of New York. Mr. Chairman, the last 24-hours of gameplaying with people's lives by the leadership has left a huge mark on the House of Representatives. I don't think our forefathers would be proud of the political games that have been played up here.

Let's look at the score of the game. This week, special interest groups have two wins, and the American people have zero.

Yesterday, with the Energy Bill, oil companies won.

Today, with the so-called Patient's Bill of Rights, insurance companies will win.

Under the House leadership deal on the so-called Patient's Bill of Rights, many of our constituents are going to have their health care needs compromised.

However, there are a few good things about the bill. Language that I've been working on to protect health care workers is included. I spent 30 years as a nurse, and I speak from experience.

When a health care worker blows the whistle on workplace abuses, they shouldn't have to fear retaliation,

For example, a nurse might be tempted to remain silent when they see a patient's quality of care being compromised.

Nurses should feel 100 percent confident that they can come forward without facing retaliation from their employer. No one should feel that their job is in jeopardy because they speak up for patient safety.

Also, my language ensuring hospitals get paid on time by HMOs is included.

Not only have HMOs been neglecting patient care, but they are also well-practiced in their denial and delay of payments to hospitals, medical group practices, doctors and other health care professionals.

Health care providers shouldn't be stuck in the middle for a bitter struggle between quality patient care and insurance company regulations.

But despite these good provisions, it's clear that special interests are the real winners in this deal.

How many more examples of special interest control must this esteemed body suffer through before doing something to change it?

I'm sure of one thing—we need campaign finance reform to get the special interests out of Congress.

Oppose the Norwood amendment.

Support the Ganske-Dingell bill. It puts patients' interests before special interests.

Ms. KILPATRICK. Mr. Chairman, I rise today to speak in favor of Representative GANSKE's Bipartisan Patients' Bill of Rights and to oppose the amendment substitute being offered. When we started this debate several years ago, we were trying to find a way to protect patients and help them to receive access to quality health care. Somehow we have strayed from our original purpose and have started trying to protect HMO's. There is something wrong with this picture.

The people of this country want security in knowing that the health care they receive is based on sound practice, not on an employer's or health care plan's bottom line. The people of this country deserve to have this assurance. I question whether or not those who oppose the Ganske bill would want for their families to face what so many of our constituents face everyday—uphill battles against HMO's in an attempt to receive the treatment their doctor has prescribed for them.

Several of my colleagues plan to offer amendments to the Ganske bill that will remove the very essence of the Patients' Bill of Rights. The amendments they plan to propose are being touted as ones that will make this a true compromise bill. It is not compromise in my eyes. If these amendments pass, the name of the bill will remain the same, but the substance of the bill will be worthless.

There are three ''poison pill amendments.'' The amendments being offered on the floor today will cost the American people millions of dollars. The underlying bill, as introduced by Representative GANSKE, includes ways to pay for the costs of this bill. The alternative plan does not pay for these costs. We are talking about costs that total over $20 million. Where is this money going to come from? Shall we just continue drawing down on the Medicare and Social Security Trust Funds?

The amendments being offered to this bill will also supersede the rights of the states. Thirty nine states, including Michigan, already have their own tort laws that work and work well. Under the alternative being offered, federal law will prevail. It will even preempt state remedies previously provided by the Supreme Court. In states that have no damage caps, they would be forced to accept the damage limitations provided by the alternative.

Under Representative GANSKE's bill, individuals have the right to have their case reviewed by an external review board. This makes sense. However, the alternative plan makes it almost impossible for a patient to prove his or her case in court. A patient must demonstrate the decision of the external review entity was completely unreasonable. It would not matter if the external reviewers were not familiar with the latest medical evidence, or if the reviewers did not consider all the facts of the patient's case. This review process is a medical one. It is vital that a patient have access to this review process, but it does not provide the due process protections that a court does. Patients should have access to the courts. To do otherwise is just

one more attempt to protect HMO's and insurers at the expense of patients.

I ask my colleagues to carefully consider the amendments and the final bill that we are being asked to vote on today. Vote against the ''poison pill amendments'' and support a true Patients' Bill of Rights. Make HMO's accountable for their actions, just as we hold doctors and hospitals accountable. Vote yes for Representative GANSKE's bill, a bill that will protect patients, not HMO's and the insurance industry.

Ms. BERKLEY. Mr. Chairman, I rise today in support of H.R. 2563, the Bipartisan Patient Protection Act.

This bill is important because it provides direct access to necessary medical care without administrative barriers for our nation's citizens. It allows doctors, not bureaucrats to make medical decisions.

The time has come in America to give doctors the right to make decisions about what kind of treatments their patients receive, how long they stay in the hospital, what type of care is given.

This bill will provide our constituents with the kind of medical care they need, when they need it and they won't have to jump through hoops to get it.

This legislation is long overdue. Let's do the right thing and pass this bill.

Mrs. MINK of Hawaii. Mr. Chairman, I rise today deeply disappointed in the total sellout of a meaningful patients' bill of rights.

For years, a bipartisan coalition of lawmakers have been working together to reform the managed care industry and develop a genuine patients' bill of rights.

A growing number of Americans get their health insurance through managed care plans. Although these plans enable many employers to provide affordable, high quality health benefits, various groups and individuals have expressed frustration with HMO's denial of necessary services and lack of an appeals process. A strong patients' bill of rights puts medical decision making back into the hands of doctors and patients and holds managed care plans accountable for failure to allow needed health care.

Today we are confronted by a compromise reached between Representative NORWOOD and the President, which no longer protects patients' health care rights.

A patients' bill of rights must allow a patient to sue their health plan for any injuries they receive if they were denied proper medical care. Of course, the lawsuit could only occur after an independent medical reviewer considers the patient's medical condition along with the most up-to-date medical knowledge and apply it to the individual's specific case.

A patients' bill of rights must close the loophole that allows HMOs to be the only industry that is protected from lawsuits.

But the agreement reached between President Bush and Representative NORWOOD does neither of these things.

Their agreement changes the external review process to prohibit the independent medical reviewer from modifying the health plans' decision. The reviewer will not even have access to the information they need in order to make a proper decision. The amendment also wipes away any current state laws relating to corporate liability of HMOs when they are acting as health care providers. This amendment preempts laws that states have passed in regards to patient protections. On the surface, the Norwood amendment allows consumers to sue in state court. But upon further examination, one realizes that consumers will never see state court. All cases will be brought to federal court because the amendment states that an action against an HMO may not be removed from federal court; only the action against an employer can be removed from federal court. Their amendment also sets unreasonably low caps on damages.

The Norwood amendment rips apart an otherwise good bill. The real Ganske-Norwood-Dingell-Berry bill would allow all insured Americans the option of seeing the doctor of their choice. This means women would have direct access to obstetric and gynecological care. Women desperately need ob-gyn care without first having to receive a referral and/or prior authorization.

The bipartisan Ganske-Dingell-Norwood bill would protect women who have mastectomies and lymph node dissections. After undergoing these procedures, women would be able to consult with their doctor on how long they need to stay in the hospital without the fear that their health plan will not cover their entire hospital stay.

The bill would also provide access to: emergency room care, without prior authorizations; guaranteed access to health care specialists; access to pediatric specialists; and access to approved FDA clinical trials for patients with life-threatening or serious illnesses.

But the liability provisions agreed to by the President and Representative NORWOOD overshadow all of these things. I simply cannot support a patients' bill of right that does not give individuals the full right to sue HMOs. The only way to hold HMOs fully accountable is to allow consumers a right of redress.

A bill of rights is an empty promise if it lacks the procedure necessary to enforce it.

This has become a bill of rights for HMO's!

This ''Compromise'' bill is a bitter retreat and forces me to vote No.

Ms. BALDWIN. Mr. Chairman, families in Wisconsin are anxious about the state of their health care. Too often, profit takes priority over patient need. Patients are losing faith that they can count on their health insurance plans to provide the care that they were promised when they enrolled and paid their premiums.

As Members of Congress, we have all tried to help our constituents who were denied care by HMOs. We have all heard their heartbreaking stories. Just this morning, I heard from a constituent of mine whose 12-year-old daughter, Francesca, has Cerebal Palsy. His daughter requires surgery to halt deterioration of her walking abilities so that she will not have to be dependent upon a wheelchair.

This father asked his HMO to allow his daughter to have surgery at a particular hospital that is not a provider in their plan because the hospital that is a provider in their plan no longer employs a specialist in this type of treatment. Instead of giving this father a referral, the HMO recommended that he switch plans. No one should fear that their insurance company would abandon them when they need it most.

I urge my colleagues to support the Ganske-Dingell bill and oppose these three amendments that will serve to deprive Americans of the patient protections they deserve.

Make no mistake about it, if these amendments pass, the bill should be renamed the HMO Bill of Rights.

Mr. UDALL of New Mexico. Mr. Chairman. The overwhelming majority of Americans view patients' rights legislation as a priority and strongly support meaningful patient protection legislation. This issue has been debated for many years now and the time for Congress to act is long overdue.

Today, however, we have the opportunity to make up for lost time and provide sound, responsible managed care reforms and meaningful protections for patients and their doctors. We can do this by passing the Ganske-Dingell Patients Protection bill.

This legislation ensures that physicians, not HMO bureaucrats, are making the medical decisions that affect patient's lives. This legislation provides for strong and effective internal and independent external review of claim denials. This legislation allows patients to hold their insurance companies and HMO's accountable for harm as a result of bureaucratic negligence, malfeasance, or incompetence.

This legislation, Mr. Chairman, has my strong support for all of these reasons that I just mentioned.

However, should this House pass the Norwood amendment or any of the other amendments later today, this legislation will be turned from the Patients Protection Act to the HMO Protection Act and will lose my support.

The Norwood Amendment carves out special protection for HMO's, rolls back patient protections and tramples states rights. I cannot support such an amendment, nor any bill that contains such an amendment.

The time for a meaningful patient's protection act is long overdue. Let's not waste the opportunity we have today by passing a bill that protects HMO's instead of patients. I urge my colleagues to support H.R. 2563, and oppose any amendments that would weaken critically important patient protections. The time for meaningful patient protection is now. Vote ''yes'' on H.R. 2563 and against weakening amendments.

Mr. PAUL. Mr. Chairman, I appreciate the opportunity to explain why I oppose all versions of the Patients' Bill of Rights. Once again Congress is staging a phony debate over which form of statism to embrace, instead of asking the fundamental question over whether Congress should be interfering in this area at all, much less examine how previous interferences in the health care market created the problems which these proposals claim to address.

The proper way to examine health care issues is to apply the same economic and constitutional principles that one would apply to every other issue. As an M.D., I know that when I advise on medical legislation that I may be tempted to allow my emotional experience as a physician to influence my views. But, nevertheless, I am acting in the role as legislator and politician.

The M.D. degree grants no wisdom as to the correct solution to our managed-care mess. The most efficient manner to deliver medical services, as it is with all goods and services, is through the free market. Economic principles determine efficiencies of markets, even the health care market, not our emotional experiences dealing with managed care.

The fundamental economic principle is that true competition assures that the consumer gets the best deal at the best price possible by putting pressure on the providers. This principle applies equally to health care as it

does to other goods and services. However, over the past fifty years, Congress has systematically destroyed the market in health care. HMOs themselves are the result of conscious government policy aimed at correcting distortions in the health care market caused by Congress. The story behind the creation of the HMOs is a classic illustration of how the unintended consequences of government policies provide a justification for further expansions of government power. During the early seventies, Congress embraced HMOs in order to address concerns about rapidly escalating health care costs.

However, it was previous Congressional action which caused health care costs to spiral by removing control over the health care dollar from consumers and thus eliminating any incentive for consumers to pay attention to prices when selecting health care. Because the consumer had the incentive to monitor health care prices stripped away and because politicians were unwilling to either give up power by giving individuals control over their health care or take responsibility for rationing care, a third way to control costs had to be created. Thus, the Nixon Administration, working with advocates of nationalized medicine, crafted legislation providing federal subsidies to HMOs and preempting state laws forbidding physicians to sign contracts to deny care to their patients. This legislation also mandated that health plans offer an HMO option in addition to traditional fee-for-service coverage. Federal subsidies, preemption of state law, and mandates on private business hardly sound like the workings of the free market. Instead, HMOs are the result of the same Nixon-era corporatist, big government mindset that produced wage-and-price controls.

I am sure many of my colleagues will think it ironic that many of the supporters of Nixon's plan to foist HMOs on the American public are today among the biggest supporters of the ''patients' rights'' legislation. However, this is not really surprising because both the legislation creating HMOs and the Patients' Bill of Rights reflect the belief that individuals are incapable of providing for their own health care needs and therefore government must control health care. The only real difference between our system of medicine and the Canadian ''single payer'' system is that in America, Congress contracted out the job of rationing health care resources to the HMOs.

No one can take a back seat to me regarding the disdain I hold for the HMO's role in managed care. This entire unnecessary level of corporatism that rakes off profits and undermines care is a creature of government interference in health care. These non-market institutions and government could have only gained control over medical care through a collusion of organized medicine, politicians, and the HMO profiteers in an effort to provide universal health care. No one suggests that we should have universal food, housing, TV, computer and automobile programs; and yet, many of the poor to much better getting these services through the marketplace as prices are driven down through competition.

We all should become suspicious when it is declared we need a new Bill of Rights, such as a Taxpayers' Bill of Rights, or now a Patients' Bill of Rights. Why do more Members not ask why the original Bill of Rights is not adequate in protecting all rights and enabling the market to provide all services? In fact, if Congress respected the Constitution we would not even be debating this bill, and we would have never passed any of the special-interest legislation that created and empowered the HMOs in the first place!

Mr. Chairman, the legislation before us is flawed not only in its effect but in the very premise that individuals have a federally-enforceable ''right'' to health care. Mixing the concept of rights with the delivery of services is dangerous. The whole notion that patient's ''rights'' can be enhanced by more edicts by the federal government is preposterous.

Disregard for constitutional limitations on government, ignorance of the basic principles of economics combined with the power of special interests influencing government policy has brought us this managed-care monster. If we pursue a course of more government management in an effort to balance things, we are destined to make the system much worse. If government mismanagement in an area that the government should not be managing at all is the problem, another level of bureaucracy, no matter how well intended, will not be helpful. The law of unintended consequences will prevail and the principle of government control over providing a service will be further entrenched in the Nation's psyche. The choice in actually is government-provided medical care and its inevitable mismanagement or medical care provided by a market economy.

Many members of Congress have convinced themselves that they can support a ''watered-down'' Patients' Bill of Rights which will allow them to appease the supporters of nationalized medicine without creating the negative consequences of the unmodified Patients' Bill of Rights, while even some supporters of the most extreme versions of this legislation say they will oppose any further steps to increase the power of government over health care. These well-intentioned members ignore the economic fact that partial government involvement is not possible. It inevitably leads to total government control. A vote for any version of a Patients' Bill of Rights is a 100 percent endorsement of the principle of government management of the health care system.

Those who doubt they are endorsing government control of medicine by voting for a modified Patients' Bill of Rights should consider that even after this legislation is ''watered-down'' it will still give the federal government the power to control the procedures for resolving disputes for every health plan in the country, as well as mandating a laundry list of services that health plans must offer to their patients. The new and improved Patients' Bill of Rights will still drive up the costs of health care, causing many to lose their insurance and lead to yet more cries for government control of health care to address the unintended consequences of this legislation.

Of course, the real power over health care will lie with the unelected bureaucrats who will implement and interpret these broad and vague mandates. Federal bureaucrats already have too much power over health care. Today, physicians struggle with over 132,000 pages of Medicare regulations. To put that in perspective, I ask my colleagues to consider that the IRS code is ''mere'' 17,000 pages. Many physicians pay attorneys as much as $7,000 for a compliance plan to guard against mistakes in filing government forms, a wise investment considering even an innocent mistake can result in fines of up to $25,000. In case doctors are not terrorized enough by the federal bureaucracy, HCFA has requested authority to carry guns on their audits!

In addition to the Medicare regulations, doctors must contend with FDA regulations (which delay the arrival and raise the costs of new drugs), insurance company paperwork, and the increasing criminalization of medicine through legislation such as the Health Insurance Portability Act (HIPPA) and the medical privacy regulations which could criminalize conversations between doctors and nurses.

Instead of this phony argument between those who believe their form of nationalized medicine is best for patients and those whose only objection to nationalized medicine is its effect on entrenched corporate interests, we ought to consider getting rid of the laws that created this medical management crisis. The ERISA law requiring businesses to provide particular programs for their employees should be repealed. The tax codes should give equal tax treatment to everyone whether working for a large corporation, small business, or self employed. Standards should be set by insurance companies, doctors, patients, and HMOs working out differences through voluntary contracts. For years it was known that some insurance policies excluded certain care. This was known up front and was considered an acceptable practice since it allowed certain patients to receive discounts. The federal government should defer to state governments to deal with the litigation crisis and the need for contract legislation between patients and medical providers. Health care providers should be free to combine their efforts to negotiate effectively with HMOs and insurance companies without running afoul of federal anti-trust laws—or being subject to regulation by the National Labor Relations Board (NLRB).

Of course, in a truly free market, HMOs and pre-paid care could and would exist—there would be no prohibition against it. The Kaiser system was not exactly a creature of the government as it the current unnatural HMO-government-created chaos we have today.

Congress should also remove all federally-imposed roadblocks to making pharmaceuticals available to physicians and patients. Government regulations are a major reason why many Americans find it difficult to afford prescription medicines. It is time to end the days when Americans suffer because the Food and Drug Administration (FDA) prevented them from getting access to medicines that where available and affordable in other parts of the world!

While none of the proposed ''Patients' Bill of Rights'' addresses the root cause of the problems in our nation's health care system, the amendment offered by the gentleman from Kentucky does expend individual control over health care by making Medical Savings Accounts (MSAs) available to everyone. This is the most important thing Congress can do to get market forces operating immediately and improve health care. When MSAs make patient motivation to save and shop a major force to reduce cost, physicians would once again negotiate fees downward with patients—unlike today where the reimbursement is never too high and hospital and MD bills are always at the maximum levels allowed. MSAs would help satisfy the American's people's desire to control their own health care and provide incentives for consumers to take more responsibility for their care.

There is nothing wrong with charity hospitals and possibly the churches once again providing care for the needy rather than through government paid programs which only maximizes costs. States can continue to introduce competition by allowing various trained individuals to provide the services that once were only provided by licensed MDs. We don't have to continue down the path of socialized medical care, especially in America where free markets have provided so much for so many.

In conclusion, Mr. Chairman, I urge my colleagues to reject the phony Patients' Bill of Rights which will only increase the power of the federal government, cause more Americans to lose their health care or receive substandard care, and thus set the groundwork for the next round of federal intervention. Instead. I ask my colleagues to embrace an agenda of returning control over health care to the American people by putting control over the health care dollar back into the hands of the individual and repealing those laws and regulations which distort the health care market. We should have more faith in freedom and more fear of the politicians and bureaucrats who think all can be made well by simply passing a Patients' Bill of Rights.

Mr. CUNNINGHAM. Mr. Chairman, I rise today to add my voice in support of the passage of a strong Patient's Bill of Rights. Congress has been working for several years to improve the delivery of health care to everyone in America. As a cancer survivor, I know how important it is to have good quality health care available when you need it.

I believe that for the most part, Americans who currently have health insurance are happy with their providers. Unfortunately, too many Americans can not afford the health care they need, and sadly, there are extreme cases where some Americans are the victims of fraud or abuse that prevent them from accessing the care that they are paying for.

I am committed to ensuring that America maintains the world's best health care system by enacting reforms giving people more choices, and more access to high quality health care. That is why I rise today in support of the Patients' Bill of Rights agreement reached by President George W. Bush and Congressman CHARLIE NORWOOD, as well as in support of an amendment to expand Medical Savings Accounts (MSA) and allow for the creation of Association Health Plans (AHP).

I am proud to support a Patients' Bill of Rights that will empower individuals and doctors to make health care choices, without the interference of government bureaucrats or trial lawyers. I support the Bush/Norwood agreement because it ensures that the American people will have swift recourse when an insurance company bean-counter decides to practice medicine.

There are a lot of people who say that when your insurance company denies coverage, you should be able to run them straight into court. Let's stop and think about that for a minute—when an individual is denied coverage by an insurance company, what is it that they really want? Coverage for life saving medical care! Lawsuits don't get you medical care. Lawsuits drag on in court for years, and line the pockets of trial lawyers. Lawsuits won't provide care for sick patients. The bottom line is that lawsuits don't save lives—but an independent medical review process will.

While we are working to improve health care for those who have insurance, we must also take action to bring this high quality care to those who cannot currently afford insurance. I support the inclusion of a provision to give millions of Americans the best patient protections of all—health care coverage. I hope that today an amendment will prevail to expand Medical Savings Accounts, and allow for the creation of Association Health Plans. Association Health Plans will allow small businesses and the self-employed the same purchasing clout and administrative savings that large, multi-state employers and labor unions currently enjoy. This provision will expand health care coverage for thousands of employees of small businesses who cannot currently afford to provide coverage to its employees.

I urge my colleagues to join me in supporting the passage of the Bush/Norwood agreement on Patients' Rights which balances the need for affordable health insurance with the need for real patient protections.

Mr. ETHERIDGE. Mr. Chairman, I rise today in support of H.R. 2563, the Patients Bill of Rights, and in opposition to all ''poison pill'' amendments and in particular the Norwood amendment.

Like many of my colleagues in this House, I strongly support the Patients Bill of Rights. In fact, the Ganske-Dingell Patients Bill of Rights provides strong patient protections. It ensures access to emergency room care, allows for clinical trials, provides for continuity of care, and holds managed care plans legally responsible for their actions. But, today we have been asked to consider a new amendment to this bill. This amendment, if passed, would gut the spirit of the Ganske-Dingell bill.

The Norwood amendment would give HMO's a rebuttable presumption in court, which means that if an HMO follows its procedures in the review process, the patient bringing a suit would be held to a higher standard of evidence that separates HMO's from any other industry, business, or individual in America. Mr. Speaker, that higher standard prevents a patient from making a case in court. That is unfair and it is wrong.

We must hold HMO's and health insurance companies accountable for their actions, and I will oppose any amendment that protects HMO's and prevents patients from getting the care they need. If this amendment passes, I will oppose the amended bill because it will become unenforceable and will let HMO's off the hook. A right that is unenforceable is no right at all.

Mr. Chairman, I have consistently supported a patient's bill of rights that is strong and enforceable. Today, I am afraid, the House majority is going to pass an insurance company's bill of rights. Maintaining health security is one of the primary challenges facing North Carolina's working families today. Families deserve to know that they can count on affordable high quality health care in their managed care plans. Making crucial decisions about a patient's health care should be the responsibility of the doctor and the patient—not some insurance company accountant.

Today's debate is about patients. They are the Americans we hear about in the news and in our communities who are sick and hurting. A real patients bill of rights provides these Americans with access to the care they need and holds managed care plans legally accountable for decisions that lead to serious injury or death. The Republican leadership supports the Norwood amendment because it will send this bill to a conference. And we all know what that means, Mr. Chairman. The Patient's Bill of Rights will die there.

America needs a Patients Bill of Rights. Our families are depending on us to give them that right today in this House. The only way we can ensure that they will get that right—the right to clinical trials, emergency room care, and to hold HMO's accountable for their decisions—is to oppose all of the ''poison pill'' amendments proposed today and support the real patient's bill of rights. The Republican bill is a fraud. It is a sham bill.

I urge all of my colleagues to support H.R. 2563, and ask that they join me in opposing the Norwood amendment and other poison pills that will kill a bill that America's patients desperately need.

Mr. COYNE. Mr. Chairman, it is time for Congress to enact a true patient protection bill. American families have already waited far too long for us to pass common-sense consumer protections.

Today, millions of Americans workers have no employer-provided health insurance, and over half of American Workers who do have employer-provided health insurance have no choice of health plan. The only health care coverage provided to those workers is a plan chosen by their employers. This plan may or may not address their health care needs and the health care needs of their families. Under current law, many of those workers and their families have no place to turn if they are harmed by decisions which are made by their insurance companies.

We need to pass a true consumer protection bill that would guarantee basic health rights for these workers. Families should be able to see specialists when they need to, appeal unfair denials, and seek emergency care when they experience severe pain. Doctors should be free to tell their patients all the options and to make medical decisions without fear of retribution from health plans. Health plans should be accountable if they make medical decisions, just as doctors are now.

Some would suggest that enacting true patient protection legislation undermines our long-held goal of health coverage for all Americans. They say that patient protection legislation could cause health insurance costs to rise and then families may become uninsured. They would have us believe that a health insurance plan that protects basic health care rights is out of reach for the average American. That is wrong. It is our responsibility to find a better way to help the uninsured than telling them to buy bad health coverage, coverage which may not be there when they need it.

Unfortunately, an unfair process to debate a meaningful patient protection bill has been set up by the Leadership of the House of Representatives today and this action effectively kills any chance of enacting a real patient protection bill. The bill being debated today contains numerous loopholes and fails to enact proper patient protections and rights. It fails to hold health plans accountable by the same standards that are applied to physicians for negligent decisions. All actions against health plans would be determined exclusively under a new federal law with no ability to apply state law. As well, when an injured patient does go to court to seek remedy, certain provisions in the legislation will tip the scales of justice in favor of the health plan. This bill also contains

week enforcement provisions that dramatically limits the ability of consumers to seek recourse for inadequate care, injury, or death. Furthermore, it forces patients to pursue remedies in an external appeals process that is neither independent or fair.

I would urge my colleagues to vote against all of the amendments. If any of the amendments are adopted, I would then urge a ''no'' vote on final passage. I hope that we can work together in the future to enact a true bipartisan patient protection bill.

Mr. TOWNS. Mr. Chairman, I rise in opposition to the amendment offered by the gentleman from Georgia. I strongly support the Ganske-Dingell-Berry Bipartisan Patient Protection Act without the Norwood-Bush ''COMPROMISE'' or any other poison pill amendments.

For the past five years, we have been fighting for true patient protection legislation only to be thwarted at every turn by a lethal combination of parliamentary maneuvers and political posturing. The Norwood-Bush Compromise is just another maneuver designed to water down real patient protection legislation.

Mr. Chairman, it is time that we return medical decisions to the people qualified to make them. It is time that we stop limiting the drugs available to patients based on an accountants' formula. It is time that we return to the American people the right to choose their own healthcare providers. The Ganske-Dingell-Berry Bipartisan Patient Protection Act stops protecting the HMO's and provides true patient protection. I support protecting patients while the amendments before us today will give all of the rights to HMO's at the expense of patients. The only thing that the Norwood-Bush ''Compromise'' compromises is a patient's access to quality care. I support the Ganske-Dingell-Berry Bipartisan Patient Protection Act because I believe that it offers patients the protection they need. Access and accountability must be the cornerstones of any true patient protection plan and Ganske-Dingell-Berry will ensure that accountability.

Don't fall for cheap imitations; the Ganske-Dingell-Berry Bipartisan Patient Protection Act is strong, enforceable patient protection legislation.

The American people are crying out for patient protection. We cannot continue to have a healthcare system that claims to offer the best healthcare in the world and yet allows business decision makers the right to limit access to top quality care. I urge my colleagues to provide true patient protection and vote for the Ganske-Dingell-Berry Bipartisan Patient Protection Act without amendments.

Mr. PASCRELL. Mr. Chairman, I stand before you to remind everyone here why we must pass the patients Bill of Rights today. It is because we must protect all Americans from the fate that befell Mr. Robert Frank Leone of Glen Ridge, N.J.—a constituent of mine.

Every year, Mr. Leone was denied a chest x-ray by his HMO despite his request. When he eventually displayed symptoms of illness, his Doctor acquiesced and his cancer was diagnosed.

Mr. Leone had non-small cell lung cancer that spread to his brain. His wife Victoria was told that he had only 2 months to live.

After successful treatment with radiation, Mr. Leone and his wife had to beg his doctors for a referral for physical therapy.

As a result of physical therapy, Mr. Leone regained much of his strength and quality of life.

But his HMO cut his physical therapy sessions as soon as he started to feel better. They said it was no longer necessary. They said it was ''preventative.''

As a result of losing his physical therapy, Mr. Leone's health began fading. Soon he could no longer walk without assistance.

Despite pleas form his wife, his HMO refused to restore Mr. Leon's physical therapy benefit. Instead, they suggested he join a health club. And that his wife Victoria should become his physical therapist! But Victoria is legally disabled!

Mr. Leone became depressed and was hospitalized and died in the hospital March 30, 1999.

I call him an HMO casualty.

If his doctor had given him a chest x-ray when he requested it, instead of denying the benefit to save money—his cancer would have been diagnosed before it had spread to his brain.

If the HMO had not limited Mr. Leone's access to physical therapy, he would have continued his improvement and would probably have not sunk into depression.

If an appeals process had been in effect, Mr. Leone and his wife could have appealed both of these denials of care.

Simply put, Mr. Leone died because the HMO was not liable for its actions. And because the HMO was not liable they could deny him care to save money and not be held accountable.

Today on the floor we are voting on H.R. 2563 to protect patients just like Mr. Leone.

But then there is this Norwood amendment.

Well, you don't have to be Columbo to recognize that the Norwood amendment is here to take the teeth out of this crucial legislation.

The Norwood amendment creates several roadblocks that would prevent patients form receiving benefits that already exist.

Additionally, the Norwood amendment supercedes state laws and forces state courts to apply federal tort law.

In fact, this amendment creates a federal cause of action for negligence where none exited before!

I am particularly interested in safeguarding strong state laws that protect patients because my state of New Jersey just recently instituted a strong patients' bill of rights that would be preempted by the Norwood amendment!

New Jersey's new patients' rights' law is much broader in scope than even the Ganske bill we are discussing here today. It covers traditional HMOs, as well as health insurance plans that are not covered by ERISA.

How can I go home and tell my constituents that the strong patients' bill of rights recently made into law in New Jersey will never have the opportunity to benefit our residents?

And that is not the only problem presented in this amendment.

The Norwood amendment creates a presumption in favor of the HMO that the patient must overcome in order to win in court.

This flies in the face of due process, a premise upon which our country is founded. It offends me to the core that this amendment not only restricts access to state law by patients but then adds an additional hurdle to their burden of proof once in court.

If the Norwood amendment had been law when Mrs. Leone was taking care of her husband, these additional obstacles would have made this heartbreaking experience even more painful. She would have had no access to her own state's laws, no fair due process, and a limited amount of damages to seek.

I shake my head whenever I think of how we could have saved Mr. Leone's life if we had only passed the Ganske bill 5 years ago.

Let's not let any more Americans die at the hands of corporations whose sole concern is the bottom line not the patients' health.

I urge all of you in joining me to vote in favor of H.R. 2563 and against the Norwood amendment. Do it for Mr. Leone and all for the future patients who we could save with this important vote.

Mr. BALDACCI. Mr. Chairman, I have long supported the efforts of Mr. NORWOOD to reform managed care. Unfortunately, I cannot support my friend's lastest legislative effort on this issue. Instead, I remain strongly in favor of the Ganske-Dingell-Berry bill, H.R. 2563. This is the only Patients' Bill of Rights legislation we are considering today with sufficient enforcement provisions. Without strong accountability, the landmark patient protections we agree are necessary will be rendered meaningless.

The Norwood amendment, based on his agreement with President Bush, is an empty shell, tipping the balance back to the insurance companies and away from patients. This Norwood plan is significantly weaker than the bill passed by the Senate.

Congressman NORWOOD's amendment places unacceptable limits on a patient's ability to hold his or her plan accountable. Self-funded plans may only be sued in federal courts. This provision limits access to state courts for many Americans covered under employer-sponsored health insurance plans. Even when a patient can seek a resolution through state court, they can only do so under federal rules, which are more restrictive for plaintiffs.

Patients have a larger burden to bear under the Norwood language. They can sue if an independent reviewer decides against them, but the legal presumption would be that the external review was correct. Under this scheme, the burden of proof is placed on the patient, who must meet a higher legal standard of proof than when he or she appealed to the review panel.

The liability provisions of this amendment are so complex and convoluted that they will only serve to dissuade patients from seeking resolution to their grievances.

Under the Norwood amendment, doctors will continue to be held to tougher state malpractice standards than HMOs. Managed care plans will still play by different rules than the physicians whose decisions these companies overrule. This is not acceptable.

Americans deserve better than this shallow version of patients' rights legislation. I urge my colleagues to soundly reject the Norwood Amendment and to support the Ganske legislation.

MR. EVANS. Mr. Chairman, today we have the opportunity to pass a strong, enforceable Patients' Bill of Rights. A bill that would return medical decisions to patients and their doctors. A bill that would strip HMOs of their unprecedented protections which allow them to make decisions about patients' care while being held accountable to no one. A bill that puts quality health care above the bottom line of insurance companies.

I hope that we will pass these new patients' rights protections today. But these rights are meaningless without the ability to enforce them. The Ganske-Dingell Patients' Bill of Rights is the only measure that protest these rights.

The so-called compromise, hastily crafted by the President and Mr. NORWOOD, renders these rights hollow. It effectively eliminates any incentive for HMOs to put the care of patients first. The limited damages that could be awarded once a HMO is found liable for the actual injury or death of a patient are not effective checks on irresponsible conduct. They are financially inconsequential compared to their enormous profit margins. It is the equivalent of a slap on the wrist.

Americans deserve better. They deserve the rights that we have promised them and an avenue of recourse when those rights are violated. I urge my colleagues to support the real Patients' Bill of Rights, not a skeleton of what could have been.

Mr. THORNBERRY. Mr. Chairman, I will vote for the Patient Protection Act legislation that the House is considering.

I voted for a similar bill two years ago because I believe that if an insurance company makes health care decisions like a doctor, it should be held responsible like a doctor. I still support a responsible patients rights bill.

We are all aware of the concerns over this measure: concerns that it could drive up healthcare costs, encourage more litigation, and result in even more people becoming uninsured, particularly in rural areas. I am especially concerned about how this bill will affect patient protection laws that have been enacted in Texas and other states around the country.

While I am not satisfied that this measure, as written fully addresses my concerns, I will vote for this bill to move it to Conference where, hopefully, many of these problems can be resolved. I stand ready to vote against the measure when it returns to the House floor if this does not occur.

It is my sincere hope, though, that this will not happen, and we will be able to reach agreement on a bill that responsibly strengthens patients' rights which the President will be able to sign into law.

Mrs. MALONEY of New York. Mr. Chairman, I rise in strong support of the Patients' Bill of Rights. It is a measure that embodies much of the spirit of our original Bill of Rights. It improves the lives of millions of Americans by guaranteeing their basic rights as health care patients. The Bipartisan Patient Protection Act enjoys strong support from the American people and grants all 167 million privately insured Americans the fundamental protections they deserve.

The bill we are debating today, H.R. 2563, was forged by the hard work of Messrs. DINGELL, GANSKE, NORWOOD, BERRY and many others. The base bill will make the health of patients, and not the wants of managed care insurers, the top priority. If a patient is harmed by HMO negligence, he or she should be able to seek legal redress; under this legislation the patient will be able to do just that. The Patients' Bill of Rights will guarantee these protections and do much more to improve the lives of millions of our citizens—all without increasing healthcare costs significantly.

We also have before us three amendments. They are three amendments that are poison pills to the underlying bill and I cannot support them. The Norwood amendment weakens the strong and sensible Dingell-Ganske bill. It holds HMOs to a lesser standard than doctors and hospitals and it undermines state patient protections. The Thomas-Fletcher amendment fully expands Medical Savings Accounts and would allow associations to offer health insurance to their members without critical state insurance standards. This amendment could actually cause more people to become uninsured. The Thomas-Boehner amendment preempts state medical malpractice and tort law. The bottom line: these amendments do not strengthen the base bill, but weaken it. If these amendments pass, I will vote ''no'' on final passage.

Protecting patients' rights inherently benefits women and their families because women are the primary healthcare consumers. More specifically, the underlying legislation gives American women direct access to an obstetrician-gynecologist and gives families direct access to specialists, such as pediatricians, without a referral. Women need regular, accessible OB/GYN care. They do not need the added expense and hassle of having to get a ''permission slip'' from their managed care insurer.

I am fortunate to represent a state that has enacted very comprehensive regulations that mandate direct-access to OB/GYNs without a gatekeeper's pre-approval. But, the Norwood amendment would roll-back state protections. I support the underlying bill because we must have a federal standard. Why? Look at the numbers: 15 states limit the number of times a women see her OB/GYN; another 12 prohibit or restrict a woman's direct access to follow-up care, even if this care is covered by her health plan; and a full 38 prohibit or restrict an OB/GYN's ability to refer a woman for necessary OB/GYN-related specialty care.

Obstetric and gynecological care is integral to women's health. As things stand now, women in some states receive better care than others. It's time we made direct access to OB/GYNs a fundamental patient protection enjoyed by all women enrolled in managed care plans.

The Bipartisan Patient Protection Act protects the health and well-being of not just women, but all Americans. Every American will have the right to choose his or her own doctor, and will not be forced to see one chosen by an HMO bureaucrat. Under this legislation, doctors, not health insurance companies, will decide which treatments, procedures and specialists are necessary.

In addition, the legislation—absent any amendments—will give patients the peace of mind that all external reviews will be conducted by independent, qualified physicians. If a plan denies coverage, the patient will be able to appeal the decision to a doctor, not an insurance clerk. And if the plan continues to deny coverage, the patient can demand a review by an unbiased, independent medical specialist, whose decision is legally binding.

Image if you or someone you love is injured by the decision of an HMO. It is only fair that he or she should be able to hold that HMO accountable. We would all rather get the care we and our families need to begin with than go to court in the end, but we should have the right to do so if administrative course of redress are exhausted. Under the Dingell-Ganske bill—absent any amendments—disputes involving medical judgments will be subject to applicable state laws; if the case involves an administrative benefit decision, the patient will be able to seek limited compensation in federal courts under federal law. Employers need not fear this bill. They will be protected from liability in either federal or state courts, unless they directly participate in a decision that causes irreparable harm or death. Indeed, employers can completely ensure that they will be fully protected from liability by choosing a ''designated decision-maker'' to assume all liability.

The critics of the Bipartisan Patient Protection Act also claim that these common-sense liability provisions will cost too much. In fact, the Congressional Budget Office reported that the liability provisions will cost only about 23 cents per employee per month. The entire bill is projected to increase premiums 4.2% over 5 years. That translates to a mere $1.20 per month. Isn't quality, protect healthcare worth the added price of a cup of coffee?

By allowing direct-access to OB/GYNs and pediatricians, authorizing physicians and not HMOs to make medical decisions, and establishing avenues for legal recourse, the Bipartisan Patients Protection Act puts the health of patients first. It will make a real difference in the quality of lives of millions of Americans. And that is what the work we do here is all about.

I urge my colleagues to vote against the three poison pill amendments and for a clean Dingell-Ganske-Norwood-Berry bill.

Ms. ROYBAL-ALLARD. Mr. Chairman, I rise in reluctant opposition to the Ganske-Dingell-Norwood-Berry Patients' Bill of Rights.

We missed an enormous opportunity today, because H.R. 2563—the Ganske-Dingell bill—could have been the giant first step to bring much-needed reform to our current health care system.

Simply speaking, the current system is stacked against patients, placing important decision-making authority in the hands of corporate bureaucrats. Today, we had the opportunity to give back the power to patients and their doctors.

Instead, the Republican-controlled House chose to adopt changes that have put patient protections in jeopardy. By stacking the deck against patients in the appeals process, and by placing caps on damages, we avoid providing any meaningful remedy to those who are injured by a negligent HMO. We essentially turn the system on its head and assume that the doctors and patients are the guilty ones, unless they can prove otherwise.

Mr. Chairman, I represent a district that is 87% Hispanic. Recent studies tell us that two-thirds of privately insured Latinos are enrolled in managed care. The Ganske-Dingell-Norwood-Berry reform bill could have had a tremendous positive impact on my constituents. And it could have helped ensure that people across the country, such as my constituents, had better access to prescription drugs, emergency care and medical specialists. But we have fallen short today.

I certainly hope that at conference we can make improvements to this bill that will put patients before the insurance companies. If we succeed in addressing the unfairness in this bill, we can then take the next step to address the needs of countless numbers of low-income workers who have no health coverage whatsoever; and the 1.2 million eligible adults and children in California who, according to a recent article in the Los Angeles Times, do not access California public health care programs.

To truly reform health care in our nation for all Americans, we must continue to work to extend coverage to the working poor, and to ensure that those who are eligible for existing health care benefits receive them.

Adequate, affordable, and accessible health care should be a right, not a privilege. The House had the change to take a significant step forward today in addressing the health care problems in our nation. But instead of taking a step forward, we have taken a step backward.

Ms. SCHAKOWSKY. Mr. Chairman, I rise in opposition to H.R. 2563, the Patient Protection Act. This bill has been so damaged by the amendments passed today, that it should be a violation of truth in advertising laws to call it a patient protection bill. It is no longer a law designed to curb HMO abuses—it has become a bill that leaves HMOs in charge of health care decision-making and preempting state laws designed to protect patients. It is a bill that is no longer deserving of its title and is no longer deserving of our support. It's an Insurance Industry Protection Act.

Earlier today, the House passed the Thomas amendment to establish Association Health Plans. Despite the arguments of its proponents, AHPs are not a step forward. Instead, AHPs will take critical state protections away from consumers and make access to health care worse for millions of Americans.

I believe that we need to make health care more affordable and accessible to small businesses and their employees. I support purchasing coops and pooling arrangements. But I could not support this amendment. Why? Because it would do more harm than good. By preempting state regulations designed to lower premiums and protect consumers, it would move us backwards not forward.

First, it would actually raise premiums for the majority of small businesses. The Congressional Budget Office estimates that 80 percent of small business employees could face premium increases as companies with healthier employees opt out of the small group market. With market fragmentation, small firms with older workers, women of child-bearing age, and workers with ongoing health problems would wind up paying more.

Second, as a result, those small businesses facing higher premiums would drop coverage. The CBO estimates that 10,000 employees—those with the highest health are needs—would lose coverage. An Urban Institute estimate is that one percent of all small firms would lose coverage.

Third, even insured consumers could face higher costs and reduced access because AHPs would be allowed to ignore state minimum benefit requirements. In Illinois, those minimum benefits include annual pap smears, prosthetic devices, mental health services, cancer screening, education on diabetes self-management, and length of stay protections for mastectomy patients. Consumer' Union opposes AHPs because ''health insurance policies would be less likely to cover potentially life-saving benefits such as mammography screening, cervical cancer screening, and drug abuse treatment.'' AHPs will lead to bare-bones coverage that leaves patients with higher medical bills or forces them to go without care.

Fourth, consumers enrolled in AHPs would have no place to go for protection, since state regulation is preempted and the U.S. Department of Labor lacks the resources or the will to respond to individual consumer complaints.

The National Governors Association, the National Conference of State Legislatures, and the National Association of Insurance Commissioners said it best when they wrote to us opposing this bill. They wrote: ''AHPs would fragment and destabilize the small group market, resulting in higher premiums for many small businesses. AHPs would be exempt from the state solvency requirements, patient protections, and oversight and thus place consumers at risk.''

I also strongly oppose the Norwood liability amendment. Many of us won election last November because we promised that we would give patients meaningful protections. We promised that we would curb HMO abuses that are injuring and killing people on a daily basis.

We promised that we would let medical professionals make medical decisions. We told doctors, nurses and other health care professionals that we would free them from managed care bureaucracy so that they can provide quality care to their patients. This amendment means that we will not be keeping those promises.

This amendment is a ruse. Behind all the fine print, it has one underlying objective: to continue the accountability shield that immunizes HMOs from responsibility when they deny care or limit care or restrict access to specialists. This amendment means that there is absolutely no guarantee that patient protections will be enforced. HMOs will be left in charge, free to continue to override doctors' decisions and deny care with virtual impunity.

This amendment provides special treatment for HMOs. It gives HMOs unique legal protections—protections denied every other industry in this country—so that they can continue to operate with immunity.

Mr. Chairman, we have done a disservice to patients and those who care for them by passing these amendments. There is an old labor song that asks the question: whose side are you on? Unfortunately, this amended bill sides with the HMOs—not patients.

Mr. HONDA. Mr. Chairman, I rise today in strong opposition to H.R. 2563, the so-called Bipartisan Patient Protection Act, as amended.

Patient protection is common sense legislation that America needs and deserves. The original bill, as proposed, provided much needed security for the 160 million Americans who receive their health coverage through managed care. It gave healthcare consumers the same protections offered in other industries. It provided accountability, minimum standards of care, and broader access to health-care options for Americans citizens.

Recently, a constituent of mine, Andrew B. Steffan of Campbell, California has had an outrageous experience, showing exactly why this important legislation is needed.

This past April, Mr. Steffan experienced difficulty breathing and chest discomfort and was transported by ambulance to Good Samaritan Hospital in San Jose. In the ambulance he was monitored by EKG and was administered oxygen to help him breath, and nitroglycerin for his chest pain. He was later diagnosed with coronary heart disease and congestive heart failure.

I can only begin to imagine the fear and anxiety experienced by Mr. Steffan and his family on that day.

What is even more incomprehensible are the problems faced by Mr. Steffan after his hospitalization. His insurance determined, after the fact, that he should have been transported to the hospital by ''other means'' and refused to pay, despite the fact that the attending physician at the hospital stated that he needed to be transported because he required cardiac monitoring.

How can an insurance professional determine after the fact that an ambulance ride was or was not necessary? Moreover, how can a health-care provider refuse to cover basic emergency services that a normal person would consider necessary? It is bad enough when serious health problems develop. One should not have to deal with a larger problem from one's insurance company.

The need for this type of legislation is inarguable. However, the Norwood Amendment, agreed to in a secret handshake deal with the President, has sabotaged any chance for real medical reform.

This amendment, which takes us backward, not forward, contains numerous provisions which enable managed care providers to never face the consequences of their actions.

Under the amended bill, HMOs are held to a different standard than doctors and hospitals. While HMOs would be shielded, with a limit of $1.5 million for punitive damages, doctors and hospitals would be hung out to dry. It allows insurance companies to make bad decisions and never be held accountable.

Under the Norwood Amendment, the injured patient must prove that ''the delay in receiving, or failure to receive, benefits is the proximate cause of personal injury to, or death of, the participant or beneficiary.'' In any medical malpractice case—unlike a running a red light being the proximate cause of the ensuing accident—there is rarely, if ever, a single cause of the injury.

The amendment overturns the good work done by states in protecting patients.

Furthermore, certain cases can be removed to the federal courts, where it is much more difficult for patients to achieve justice.

Yes, America's citizens need healthcare protection. But a sham, ineffective bill is not the answer. What good are patient protections if these rights cannot be effectively enforced in court?

I urge my colleagues to follow the lead of the other body and pass forceful, effective, meaningful legislation.

Mr. RUSH. Mr. Chairman, like many of my colleagues, I have been a staunch advocate for patients' rights. I have looked forward to the day when this House would once again pass a strong patients' bill of rights which would bring back responsibility and accountability to the relationship between HMOs and their patients.

The Bipartisan Patient Protection Act, H.R. 2563, as originally brought to the Floor today by Representative JOHN DINGELL and Representative GREG GANSKE was a model of bipartisanship and fairness. The bill brought equality to the patient and HMO relationship by providing for an internal and external review process of denials of care and permitting patients to sue their HMOs in state and federal courts. To ensure that the pendulum did not swing too far to one side, the bill also capped punitive damages at $5 million. Further, to protect employers from frivolous suits, the bill only held employers liable if they administered their plan themselves. Clearly, the

bill as it was originally intended provided patients the means they needed to protect their right to quality care.

Unfortunately, with the adoption of Representative NORWOOD's amendment, the Bipartisan Patient Protection Act was stripped of its provisions allowing patients to sue their HMOs for the unfair denial of needed health care. Patients will now find themselves in an even more hostile and unresponsive environment.

It is for this reason that I must regrettably rise in opposition to the Bipartisan Patient Protection Act as amended by Representative CHARLES NORWOOD. I can only hope that the changes made to the Bipartisan Patient Protection Act can be revisited in conference.

Mr. GILMAN. Mr. Chairman, I rise today in support of H.R. 2563, the Bipartisan Patient Protection Act of 2001, otherwise known as the Ganske-Dingell-Norwood bill. Over the past 6 years, I have worked with my colleagues, Dr. GANSKE, Mr. DINGELL and Dr. NORWOOD, on trying to bring a comprehensive, bipartisan patient protection bill to the floor, and I believe that H.R. 2563 is this bill.

The Ganske-Dingell bill will provide individuals with managed care insurance plans, with an unprecedented amount of protections, including: the right to choose their own doctor, access to specialists, gag clause protections, information disclosure and access to emergency services. Moreover, the passage of this bill will mark the first time that patients throughout the nation will have the ability to hold their HMOs accountable for injuries or deaths which result from denials or delays of claims by the HMO.

H.R. 2563, has the support of over 800 organizations, including the American Medical Association, American Cancer Society, American Heart Association, National Breast Cancer Coalition, Patient Access to Responsible Care and National Health Association. These organizations recognize that the Ganske-Dingell bill is going to provide the necessary protections against abuses by the managed care industry.

I applaud the efforts of Representatives GANSKE, DINGELL, NORWOOD and BERRY for bring this important measure to the floor and for their dedication to this issue through the years.

Moreover, I commend Dr. NORWOOD for his continued commitment to ensuring that a Patients' Bill of Rights passes the House and has the opportunity to receive full and fair consideration by the Congress and the President. I understand that he has given his best efforts to negotiate a sound amendment which will have the opportunity to be reviewed and reconsidered in the legislative process.

Having said that, I do have concerns with the amendment introduced by Representative NORWOOD.

Foremost, the Norwood amendment fails to hold health plans accountable by the same standards that apply to physicians for negligent medical decisions. Rather than defer to state statutory law and hundreds of years of common law, the Norwood amendment would create a new status of health plans that injure or kill patients by their negligent treatment decisions. All actions against health plans would be determined exclusively under a new federal law while doctors and hospitals would be subject to less stringent state laws.

Additionally, the Norwood amendment includes a provision that grants health plans a ''rebuttable presumption'' in court when the external review panel has found in their favor. A patient would now be forced to prove that the decision of the external review panel was unreasonable, rather than only providing that the HMO was responsible for serious injury or death.

The most difficult portion of the Norwood amendment is that it strips the states of the rights they currently enjoy. It fails to recognize those states that already have external review systems and not allowing them to remain in place. Under Ganske-Dingell, states that already have a substantially similar, if not superior external review system in place, would be able to continue overseeing these systems. Ganske-Dingell sets a federal standard and allows states to provide additional protections if they choose to, while the Norwood amendment mandates a federal cap which prohibits states from providing additional protections.

States like New York, which currently has a superior external review process compared to the regulations outlined in Norwood, would be forced to follow an inferior external review system.

I hoped to come to the floor today to support a bipartisan proposal that had the full backing of all 4 sponsors of H.R. 2563, the House leadership and the White House.

Unfortunately, we have come to a cross roads. Our sponsors are in disagreement, the President has pledged, for his reasons, to veto the Ganske-Dingell-Norwood bill in its present form, the Minority has begun to politicize this issue to the detriment of real reform, and we are now forced to make a decision between passing a Patient's Bill of Rights or passing up the opportunity to allow myself, Dr. GANSKE, Dr. NORWOOD, Mr. DINGELL, Mr. BERRY and other Members of Congress to pressure the Senate and the White House in conference to remedy those provisions which weaken this measure.

In light of this unfortunate situation, I will not kill our opportunity to continue our work on behalf of patient's throughout our nation and pass a bi-partisan Patient's Bill of Rights.

I call on my colleagues, the Senate, and the President to recognize that this is an unfinished work and I look forward to working with all concerned so that after five long years we can finally complete this important measure.

Mr. ROSS. Mr. Chairman we need a real Patients Bill of Rights—one that truly takes the medical decisions out of the hands of the big health insurance company bureaucrats and the big HMOs and puts them back where they belong with physicians, nurses, and patients; one that allows patients to hold their HMOs accountable when they make bad medical decisions. That's what our constituents are asking for. That's what the Ganske-Dingell-Berry bill would do.

I'm sick and tired of the scare tactics the big health insurance companies and the big HMOs have been using with our small business owners. I own a small business with 15 employees back home. We provide health insurance to our employees. And I can tell you, the scare tactics that these HMOs are putting out in regard to increased premiums and potential lawsuits are simply that—scare tactics.

The state of Texas has this law on the books, and it is working. It's making the big HMOs accountable to their patients on the front end, and that is why there have only been 17 lawsuits filed in the state of Texas—a very large state— since the law was enacted in 1997.

The Norwood Compromise overrides states like Texas who already have patient protection laws on their books. It rolls back patient protections and shields HMOs from the consequences of their own bad medical decisions, unlike doctors and hospitals, who will be left to defend themselves.

This is not a patient bill of rights. This is an HMO and health insurance companies' bill of rights. Mr. Chairman, I urge my colleagues to reject this legislation written by the big HMOs for the big HMOs. I urge my colleagues to vote against final passage of this measure.

Mr. UDALL of Colorado. Mr. Chairman, since being elected to Congress, I have worked hard for a meaningful Patient's Bill of Rights. But I cannot support the White House proposal that was crafted in the wee hours of the night because it favors HMOs over patients.

This proposal is bad for Colorado. Patients will not have the full right to sue their HMO if it unfairly denies them access to critical medical care. And worse yet, the White House proposal overrides strong patients' rights laws already enacted in Colorado. When I served in the Colorado State House, we put in lots of hard work on a bipartisan basis to enact strong, meaningful patient protections. This deal will wipe away those protections with one fell swoop. We should keep our strong state protections in tact and not let the weaker federal laws take precedence.

So Mr. Chairman, I stand with the American Medical Association and the millions of Americans who will be greatly harmed by this legislation. I am disappointed that the Republican Leadership has worked with the White House to strike a deal that is acceptable to the President and unacceptable to patients and doctors. They have hijacked a good bill and filled it with protections for special interests. I hope that the House-Senate conference committee will come up with a bill that reflects the McCain bill that was approved in the Senate earlier this year.

Ms. LEE. Mr. Chairman, I am deeply disappointed in how the Republicans have stripped and completely weakened H.R. 2563, the Bipartisan Ganske-Dingell Patient Protection Act of 2001. This Patient Bill of Rights originally included strong patient protections that would have ensured timely access to high quality health care for the millions of Americans with private health insurance.

This bill was a bipartisan effort to protect our patients but some Republicans decided to add some terrible provisions that protected HMOs over individuals. The original Patients Bill of Rights, the one I supported, would have given individuals more access to emergency medical services, access to specialty care, access to essential medication, access to clinical trials, and direct access to pediatricians as well as Ob-Gyn care. This bill would have also protected the doctor-patient relationships by ensuring health professionals are free to provide information about a patient's medical treatment options.

H.R. 2563 did address the importance of allowing patients to appeal their health plans' decision as well as holding HMOs accountable for their actions. This bill would have established an independent, speedy external review process for patients dissatisfied with the results of the internal review. H.R. 2563 would

have allowed individuals the right to sue when a medical judgment resulted in injury or death.

The Republicans offered three amendments of which two passed to the Patient Protection Act that severely weakened major provisions. The first amendment fully expands medical savings accounts (MSA) which only benefit wealthier and healthier people. This provision will directly increase health care costs for those who remain in traditional insurance and managed care plans.

The second Republican amendment weakens enforcement provisions found within H.R. 2563, makes it nearly impossible to pursue cases in state court, and stacks the deck against patients who have been harmed by insurance companies.

Now that these two poisonous amendments have been attached to H.R. 2563, I can no longer support this bill because patients will no longer be protected. Individuals throughout our nation have been growing more and more frustrated with an inadequate health care system that does not listen to the needs of our people. The original bill would have provided many protections that are essential to upholding our patients' rights. But unfortunately, the bill was completely stripped by the Republicans who want to protect HMO insurance groups over average Americans.

I was a stronger supporter of this bill but I now have to vote against this proposal. It's a shame that we cannot pass a real patients' bill of rights, and it's a shame that we are not addressing the 44 million individuals without any kind of health care coverage. I believe we need to provide all individuals access to affordable health care in order to improve our overall quality of life and health. This Congress should support a real Patients' bill of Rights and quality health care for everyone in this country. Today, this Congress did neither.

Mr. BACA. Mr. Chairman, we are about to engage in a battle to protect patients' rights, our rights and the rights of our loved ones. I believe that every American, those in the 42nd district of California, those across the Nation are all entitled to quality health care.

We can no longer take for granted that HMOs will let doctors base decisions on our health needs. We can no longer assume that HMOs care about our health concerns over the companies' bottom line.

The bottom line is that HMOs care only about one thing: Profits! Profits! Profits! Profits! instead of health needs! health needs! health needs! health needs!

Too often today, HMOs are not making sound decisions about the health needs of our families, our children, our parents and grandparents!

We must shift priorities away from money and back to the patient! Away from HMOS and back to our doctors!

This debate is about taking care of the American people that invest in our country every day! It is about working mothers in San Bernardino with sick children at home. It is about a husband or wife in Rialto having to take time off work to see a doctor only to be referred to another doctor.

This is about direct access for women to see an ob-gyn, for your child to see a pediatrician, to emergency care specialists, this is a matter of life or death!

Let's not forget about those who have dedicated their lives to our health and happiness, our parents, our grandparents, the elderly.

This can no longer be about profits! This is about healing the sick! This is about making sure that the health needs of every American are taken care of.

Health care should be the least of our worries! You shouldn't have to worry about losing your job, you shouldn't have to worry about losing your home because your health plan wouldn't cover you in your time of need!

This is America. We care about everyone in America. We should not have to live in fear. The American people should not live in fear of sickness, the American people do not deserve to fear needing medical attention!

The least we can do is guarantee better health care for working Americans than the health care provided to those in our prison systems!

That is why I joined a bipartisan coalition, to co-sponsor H.R. 2563, the Patient Protection Act, a strong, enforceable patients' bill of rights, the only real patients' bill of rights. I will fight against efforts to weaken this bill with amendments negotiated in the dead of night.

President Bush claims he is committed to working on a bipartisan basis for the good of our people. Here is his chance! This is not a partisan issue, it is about protecting patients' rights to quality health care. It is really about the health of our country! ''Read my lips'' were his Dad's famous words. I urge the president to cut the lipservice, prove your commitment to bipartisanship! Commit to America's health Mr. President, not to the health of HMOs, not to the health of your friends in big business!

This patients' bill of rights is the medicine to cure the out-of-control greed of the HMOs. I urge you to hold HMOs accountable, to fight for patients' rights!

Remember who we are talking about. We are talking about the health of our children, our parents and our neighbors. I urge you to vote for the Patient Protection Act, H.R. 2563, without amendments that weaken patient protection.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the bill is considered read for amendment under the 5-minute rule.

The text of H.R. 2563 is as follows:

H.R. 2563

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Patient Protection Act''.

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

TITLE I—IMPROVING MANAGED CARE

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

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 102.

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

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a participant, beneficiary, or enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for a periodic evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

SEC. 102. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

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

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits, and of the right of the participant, beneficiary, or enrollee to an internal appeal under section 103.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial 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 claim. 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 subsection (b)(1), 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.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claim for such benefits without regard to whether and when a written confirmation of such request is made.

(b) TIMELINE FOR MAKING DETERMINATIONS.—

(1) PRIOR AUTHORIZATION DETERMINATION.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization and in no case later than 28 days after the date of the claim for benefits is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, and a health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on a claim for benefits described in such subparagraph when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain 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 is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE.—

(i) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an appeal under section 103(b)(3) to be completed before the termination or reduction takes effect.

(II) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) RETROSPECTIVE DETERMINATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination (or, in the case described in subparagraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph).

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(2) the procedures for obtaining additional information concerning the determination; and

(3) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with section 103.

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

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

SEC. 103. INTERNAL APPEALS OF CLAIMS DENIALS.

(a) RIGHT TO INTERNAL APPEAL.—

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

(2) TIME FOR APPEAL.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall ensure that a participant, beneficiary, or enrollee (or authorized 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 participant, beneficiary, enrollee, or representative proceed directly to seek further appeal through external review under section 104 or otherwise.

(b) TIMELINES FOR MAKING DETERMINATIONS.—

(1) ORAL REQUESTS.—In the case of an appeal of a denial of a claim for benefits under this section that involves an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may request such appeal orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for an appeal of a denial, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for an appeal without regard to whether and when a written confirmation of such request is made.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an appeal of a 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.

(3) PRIOR AUTHORIZATION DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in this paragraph or paragraph (4), a group health plan, and a health insurance issuer offering health insurance coverage, shall make a determination on an appeal of a denial of a claim for benefits under this subsection in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 28 days after the date the request for the appeal is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, and a health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on an appeal of a denial of a claim for benefits described in subparagraph (A), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain 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 such appeal is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE DETERMINATIONS.—

(i) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review determination described in section 102(b)(1)(C)(i)(I), which results in a termination or reduction of such care, the plan or issuer must provide notice of the determination on the appeal under this section by telephone and in printed form to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an external appeal

under section 104 to be completed before the termination or reduction takes effect.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(4) RETROSPECTIVE DETERMINATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a denial of a claim for benefits in no case later than 30 days after the date on which the plan or issuer receives necessary information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 60 days after the date the request for the appeal is received.

(c) CONDUCT OF REVIEW.—

(1) IN GENERAL.—A review of a denial of a claim for benefits under this section shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

(2) PEER REVIEW OF MEDICAL DECISIONS BY HEALTH CARE PROFESSIONALS.—A review of an appeal of a denial of a claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts—

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

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

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

(d) NOTICE OF DETERMINATION.—

(1) IN GENERAL.—Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of completion of the review (or, in the case described in subparagraph (B) or (C) of subsection (b)(3), within the 72-hour or applicable period referred to in such subparagraph).

(2) FINAL DETERMINATION.—The decision by a plan or issuer under this section shall be treated as the final determination of the plan or issuer on a denial of a claim for benefits. The failure of a plan or issuer to issue a determination on an appeal of a denial of a claim for benefits under this section within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits for purposes of proceeding to external review under section 104.

(3) REQUIREMENTS OF NOTICE.—With respect to a determination made under this section, the notice described in paragraph (1) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

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

(C) notification of the right to an independent external review under section 104 and instructions on how to initiate such a review.

SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide in accordance with this section participants, beneficiaries, and enrollees (or authorized representatives) with access to an independent external review for any denial of a claim for benefits.

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

(1) TIME TO FILE.—A request for an independent external review under this section shall be filed with the plan or issuer not later than 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the denial under section 103(d) or notice of waiver of internal review under section 103(a)(4) or the date on which the plan or issuer has failed to make a timely decision under section 103(d)(2) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(2) FILING OF REQUEST.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a group health plan, or health insurance issuer offering health insurance coverage, may—

(i) except as provided in subparagraph (B)(i), require that a request for review be in writing;

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

(iii) except if waived by the plan or issuer under section 103(a)(4), condition access to an independent external review under this section upon a final determination of a denial of a claim for benefits under the internal review procedure under section 103;

(iv) except as provided in subparagraph (B)(ii), require payment of a filing fee to the plan or issuer of a sum that does not exceed $25; and

(v) require that a request for review include the consent of the participant, beneficiary, or enrollee (or authorized representative) for the release of necessary medical information or records of the participant, beneficiary, or enrollee to the qualified external review entity only for purposes of conducting external review activities.

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(i) ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request for such review may be made orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such a review without regard to whether and when a written confirmation of such request is made.

(ii) EXCEPTION TO FILING FEE REQUIREMENT.—

(I) INDIGENCY.—Payment of a filing fee shall not be required under subparagraph (A)(iv) where there is a certification (in a form and manner specified in guidelines established by the appropriate Secretary) that the participant, beneficiary, or enrollee is indigent (as defined in such guidelines).

(II) FEE NOT REQUIRED.—Payment of a filing fee shall not be required under subparagraph (A)(iv) if the plan or issuer waives the internal appeals process under section 103(a)(4).

(III) REFUNDING OF FEE.—The filing fee paid under subparagraph (A)(iv) shall be refunded if the determination under the independent external review is to reverse or modify the denial which is the subject of the review.

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

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

(1) IN GENERAL.—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering health insurance coverage, the plan or issuer shall immediately refer such request, and forward the plan or issuer's initial decision (including the information described in section 103(d)(3)(A)), to a qualified external review entity selected in accordance with this section.

(2) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant, beneficiary, or enrollee (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with information that is necessary to conduct a review under this section, as determined and requested by the entity. Such information 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 clause (ii) or (iii) of subsection (e)(1)(A), by such earlier time as may be necessary to comply with the applicable timeline under such clause.

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

(A) IN GENERAL.—With respect to a request referred to a qualified external review entity under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless the entity determines that—

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

(ii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

(iii) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant, beneficiary, or enrollee who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

(iv) the denial of the claim for benefits is a decision as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage unless the decision is a denial described in subsection (d)(2).

Upon making a determination that any of clauses (i) through (iv) applies with respect to the request, the entity shall determine that the denial of a claim for benefits involved is not eligible for independent medical review under subsection (d), and shall provide notice in accordance with subparagraph (C).

(B) PROCESS FOR MAKING DETERMINATIONS.—

(i) NO DEFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no deference given to determinations made by the plan or issuer or the recommendation of a treating health care professional (if any).

(ii) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified personnel to make determinations under this section.

(C) NOTICES AND GENERAL TIMELINES FOR DETERMINATION.—

(i) NOTICE IN CASE OF DENIAL OF REFERRAL.—If the entity under this paragraph 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 determination within the overall timeline that is applicable to the case under review as described in subsection (e), except that if the entity determines that a referral to an independent medical reviewer is not required, the entity shall provide notice of such determination to the participant, beneficiary, or enrollee (or authorized representative) within such timeline and within 2 days of the date of such determination.

(d) INDEPENDENT MEDICAL REVIEW.—

(1) IN GENERAL.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial involved to an independent medical reviewer for the conduct of an independent medical review under this subsection.

(2) MEDICALLY REVIEWABLE DECISIONS.—A denial of a claim for benefits is eligible for independent medical review if the benefit for the item or service for which the claim is made would be a covered benefit under the terms and conditions of the plan or coverage but for one (or more) of the following determinations:

(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—A determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—A determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms.

(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(A) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to whether or not the denial of a claim for a benefit that is the subject of the review should be upheld, reversed, or modified.

(B) STANDARD FOR DETERMINATION.—The independent medical reviewer's determination relating to the medical necessity and appropriateness, or the experimental or investigational nature, or the evaluation of the medical facts, of the item, service, or condition involved shall be based on the medical condition of the participant, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.

(C) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)). Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage documents) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required: *Provided*, That the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

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

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

(ii) The recommendation of the treating health care professional and the evidence, guidelines, and rationale used by the treating health care professional in reaching such recommendation.

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

(iv) The plan or coverage document.

(E) INDEPENDENT DETERMINATION.—In making determinations under this section, a qualified external review entity and an independent medical reviewer shall—

(i) consider the claim under review 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

(iii) with respect to a determination to reverse or modify the denial under review, a timeframe within which the plan or issuer must comply with such determination.

(G) NONBINDING NATURE OF ADDITIONAL RECOMMENDATIONS.—In addition to the determination under subparagraph (F), the reviewer may provide the plan or issuer and the treating health care professional with additional recommendations in connection with such a determination, but any such recommendations shall not affect (or be treated as part of) the determination and shall not be binding on the plan or issuer.

(e) TIMELINES AND NOTIFICATIONS.—

(1) TIMELINES FOR INDEPENDENT MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION DETERMINATION.—

(i) IN GENERAL.—The independent medical reviewer (or reviewers) shall make a determination on a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days after the date of receipt of information under subsection (c)(2) if the review involves a prior authorization of items or services and in no case later than 21 days after the date the request for external review is received.

(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i) and subject to clause (iii), the independent medical reviewer (or reviewers) shall make an expedited determination on a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination, and a health care professional certifies, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain 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 case later than 60 days after the date the request for external review is received by the qualified external review entity.

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if

any) receives a copy of the written determination of the independent medical reviewer prepared under subsection (d)(3)(F). Nothing in this paragraph shall be construed as preventing an entity or reviewer from providing an initial oral notice of the reviewer's determination.

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

(f) COMPLIANCE.—

(1) APPLICATION OF DETERMINATIONS.—

(A) EXTERNAL REVIEW DETERMINATIONS BINDING ON PLAN.—The determinations of an external review entity and an independent medical reviewer under this section shall be binding upon the plan or issuer involved.

(B) COMPLIANCE WITH DETERMINATION.—If the determination of an independent medical reviewer is to reverse or modify the denial, the plan or issuer, upon the receipt of such determination, shall authorize coverage to comply with the medical reviewer's determination in accordance with the timeframe established by the medical reviewer.

(2) FAILURE TO COMPLY.—

(A) IN GENERAL.—If a plan or issuer fails to comply with the timeframe established under paragraph (1)(B) with respect to a participant, beneficiary, or enrollee, where such failure to comply is caused by the plan or issuer, the participant, beneficiary, or enrollee may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

(B) REIMBURSEMENT.—

(i) IN GENERAL.—Where a participant, beneficiary, or enrollee obtains items or services in accordance with subparagraph (A), the plan or issuer involved shall provide for reimbursement of the costs of such items or services. Such reimbursement shall be made to the treating health care professional or to the participant, beneficiary, or enrollee (in the case of a participant, beneficiary, or enrollee who pays for the costs of such items or services).

(ii) AMOUNT.—The plan or issuer shall fully reimburse a professional, participant, beneficiary, or enrollee under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items or services) so long as the items or services were provided in a manner consistent with the determination of the independent medical reviewer.

(C) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant, beneficiary, or enrollee in accordance with this paragraph, the professional, participant, beneficiary, or enrollee may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is owed by the plan or issuer and any necessary legal costs or expenses (including attorney's fees) incurred in recovering such reimbursement.

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

(3) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(A) MONETARY PENALTIES.—

(i) IN GENERAL.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion of a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(ii) ADDITIONAL PENALTY FOR FAILING TO FOLLOW TIMELINE.—In any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant, beneficiary, or enrollee involved.

(B) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in subparagraph (A) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such subparagraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity to be covered, or has failed to take an action for which such person is responsible under the terms and conditions of the plan or coverage and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(i) to cease and desist from the alleged action or failure to act; and

(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(C) ADDITIONAL CIVIL PENALTIES.—

(i) IN GENERAL.—In addition to any penalty imposed under subparagraph (A) or (B), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(I) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity to be covered; or

(II) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or coverage.

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

(I) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice; or

(II) $500,000.

(D) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in subparagraph (C)(i) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(4) PROTECTION OF LEGAL RIGHTS.—Nothing in this subsection or subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

(g) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—

(1) IN GENERAL.—In referring a denial to 1 or more individuals to conduct independent medical review under subsection (c), the qualified external review entity shall ensure that—

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

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

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

(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

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

(3) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

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

(ii) not have a material familial, financial, or professional relationship with such a party; and

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

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

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

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

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

(III) the fact of such an affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative) and neither party objects; and

(IV) the affiliated individual is not an employee of the plan or issuer and does not provide services exclusively or primarily to or on behalf of the plan or issuer;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative), and neither party objects; or

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

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

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

(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

(ii) by a non-physician health care professional, a reviewer (or reviewers) shall include at least one practicing non-physician health care professional of the same or similar specialty as the non-physician health care

professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

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

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

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

(A) not exceed a reasonable level; and

(B) not be contingent on the decision rendered by the reviewer.

(7) RELATED PARTY DEFINED.—For purposes of this section, the term ''related party'' means, with respect to a denial of a claim under a plan or coverage relating to a participant, beneficiary, or enrollee, any of the following:

(A) The plan, plan sponsor, or issuer involved, or any fiduciary, officer, director, or employee of such plan, plan sponsor, or issuer.

(B) The participant, beneficiary, or enrollee (or authorized representative).

(C) The health care professional that provides the items or services involved in the denial.

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

(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

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

(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

(1) SELECTION OF QUALIFIED EXTERNAL REVIEW 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 State in a manner determined by the State to assure an unbiased determination.

(2) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).

(3) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—

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

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

Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(iv) or costs incurred by the participant, beneficiary, or enrollee (or authorized representative) or treating health care professional (if any) in support 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 activities consistent with the applicable requirements of this section and standards specified in subparagraph (C), including that it will not conduct any external review activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).

(v) The entity meets such other requirements as the appropriate Secretary provides by regulation.

(B) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—

(I) is not a related party (as defined in subsection (g)(7));

(II) does not have a material familial, financial, or professional relationship with such a party; and

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

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

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—

(I) not exceed a reasonable level; and

(II) not be contingent on any decision rendered by the entity or by any independent medical reviewer.

(C) CERTIFICATION AND RECERTIFICATION PROCESS.—

(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—

(I) under a process that is recognized or approved by the appropriate Secretary; or

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

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

(ii) PROCESS.—The appropriate Secretary shall not recognize or approve a process under clause (i)(I) unless the process applies standards (as promulgated in regulations) that ensure that a qualified external review entity—

(I) will carry out (and has carried out, in the case of recertification) the responsibilities of such an entity in accordance with this section, including meeting applicable deadlines;

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

(III) will maintain (and has maintained, in the case of recertification) appropriate confidentiality with respect to individually identifiable health information obtained in the course of conducting external review activities; and

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

(iii) APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of clause (i)(II), the appropriate Secretary may approve a qualified private standard-setting organization if such Secretary finds that the organization only certifies (or recertifies) external review entities that meet at least the standards required for the certification (or recertification) of external review entities under clause (ii).

(iv) CONSIDERATIONS IN RECERTIFICATIONS.—In conducting recertifications of a qualified external review entity under this paragraph, the appropriate Secretary or organization conducting the recertification shall review compliance of the entity with the requirements for conducting external review activities under this section, including the following:

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

(II) Adherence to applicable deadlines (both by the entity and by independent medical reviewers it refers cases to).

(III) Compliance with limitations on compensation (with respect to both the entity and independent medical reviewers it refers cases to).

(IV) Compliance with applicable independence requirements.

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—A certification or recertification provided under this paragraph shall extend for a period not to exceed 2 years.

(vi) REVOCATION.—A certification or recertification under this paragraph may be revoked by the appropriate Secretary or by the organization providing such certification upon a showing of cause. The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has

a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

(viii) SUFFICIENT NUMBER OF ENTITIES.—The appropriate Secretary shall certify and recertify a number of external review entities which is sufficient to ensure the timely and efficient provision of review services.

(D) PROVISION OF INFORMATION.—

(i) IN GENERAL.—A qualified external review entity shall provide to the appropriate Secretary, in such manner and at such times as such Secretary may require, such information (relating to the denials which have been referred to the entity for the conduct of external review under this section) as such Secretary determines appropriate to assure compliance with the independence and other requirements of this section to monitor and assess the quality of its external review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

(ii) INFORMATION TO BE INCLUDED.—The information described in this subclause with respect to an entity is as follows:

(I) The number and types of denials for which a request for review has been received by the entity.

(II) The disposition by the entity of such denials, including the number referred to a independent medical reviewer and the reasons for such dispositions (including the application of exclusions), on a plan or issuer-specific basis and on a health care specialty-specific basis.

(III) The length of time in making determinations with respect to such denials.

(IV) Updated information on the information required to be submitted as a condition of certification with respect to the entity's performance of external review activities.

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

(I) IN GENERAL.—In the case of a qualified external review entity which is certified (or recertified) under this subsection by a qualified private standard-setting organization, at the request of the organization, the entity shall provide the organization with the information provided to the appropriate Secretary under clause (i).

(II) ADDITIONAL INFORMATION.—Nothing in this subparagraph shall be construed as preventing such an organization from requiring additional information as a condition of certification or recertification of an entity.

(iv) USE OF INFORMATION.—Information provided under this subparagraph may be used by the appropriate Secretary and qualified private standard-setting organizations to conduct oversight of qualified external review entities, including recertification of such entities, and shall be made available to the public in an appropriate manner.

(E) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is employed by any such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 601, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

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

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

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

SEC. 105. HEALTH CARE CONSUMER ASSISTANCE FUND.

(a) GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a fund, to be known as the ''Health Care Consumer Assistance Fund'', to be used to award grants to eligible States to carry out consumer assistance activities (including programs established by States prior to the enactment of this Act) designed to provide information, assistance, and referrals to consumers of health insurance products.

(2) STATE ELIGIBILITY.—To be eligible to receive a grant under this subsection a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes—

(A) the manner in which the State will ensure that the health care consumer assistance office (established under paragraph (4)) will educate and assist health care consumers in accessing needed care;

(B) the manner in which the State will coordinate and distinguish the services provided by the health care consumer assistance office with the services provided by Federal, State and local health-related ombudsman, information, protection and advocacy, insurance, and fraud and abuse programs;

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

(D) the manner in which the State will oversee the health care consumer assistance office, its activities, product materials and evaluate program effectiveness;

(E) the manner in which the State will ensure that funds made available under this section will be used to supplement, and not supplant, any other Federal, State, or local funds expended to provide services for programs described under this section and those described in subparagraphs (C) and (D);

(F) the manner in which the State will ensure that health care consumer office personnel have the professional background and training to carry out the activities of the office; and

(G) the manner in which the State will ensure that consumers have direct access to consumer assistance personnel during regular business hours.

(3) AMOUNT OF GRANT.—

(A) IN GENERAL.—From amounts appropriated under subsection (b) for a fiscal year, the Secretary shall award a grant to a State in an amount that bears the same ratio to such amounts as the number of individuals within the State covered under a group health plan or under health insurance coverage offered by a health insurance issuer bears to the total number of individuals so covered in all States (as determined by the Secretary). Any amounts provided to a State under this subsection that are not used by the State shall be remitted to the Secretary and reallocated in accordance with this subparagraph.

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

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

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

(A) IN GENERAL.—From amounts provided under a grant under this subsection, a State shall, directly or through a contract with an independent, nonprofit entity with demonstrated experience in serving the needs of health care consumers, provide for the establishment and operation of a State health care consumer assistance office.

(B) ELIGIBILITY OF ENTITY.—To be eligible to enter into a contract under subparagraph (A), an entity shall demonstrate that it has the technical, organizational, and professional capacity to deliver the services described in subsection (b) to all public and private health insurance participants, beneficiaries, enrollees, or prospective enrollees.

(C) EXISTING STATE ENTITY.—Nothing in this section shall prevent the funding of an existing health care consumer assistance program that otherwise meets the requirements of this section.

(b) USE OF FUNDS.—

(1) BY STATE.—A State shall use amounts provided under a grant awarded under this section to carry out consumer assistance activities directly or by contract with an independent, non-profit organization. An eligible entity may use some reasonable amount of such grant to ensure the adequate training of personnel carrying out such activities. To receive amounts under this subsection, an eligible entity shall provide consumer assistance services, including—

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

(B) the dissemination of appropriate educational materials on available health insurance products and on how best to access health care and the rights and responsibilities of health care consumers;

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

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

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

(F) the provision of information and assistance, including acting as an authorized representative, regarding internal, external, or administrative grievances or appeals procedures in nonlitigative settings to appeal the denial, termination, or reduction of health care services, or the refusal to pay for such services, under a group health plan or health insurance coverage offered by a health insurance issuer.

(2) CONFIDENTIALITY AND ACCESS TO INFORMATION.—

(A) STATE ENTITY.—With respect to a State that directly establishes a health care consumer assistance office, such office shall establish and implement procedures and protocols in accordance with applicable Federal and State laws.

(B) CONTRACT ENTITY.—With respect to a State that, through contract, establishes a

health care consumer assistance office, such office shall establish and implement procedures and protocols, consistent with applicable Federal and State laws, to ensure the confidentiality of all information shared by a participant, beneficiary, enrollee, or their personal representative and their health care providers, group health plans, or health insurance insurers with the office and to ensure that no such information is used by the office, or released or disclosed to State agencies or outside persons or entities without the prior written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) of the individual or personal representative. The office may, consistent with applicable Federal and State confidentiality laws, collect, use or disclose aggregate information that is not individually identifiable (as defined in section 164.501 of title 45, Code of Federal Regulations). The office shall provide a written description of the policies and procedures of the office with respect to the manner in which health information may be used or disclosed to carry out consumer assistance activities. The office shall provide health care providers, group health plans, or health insurance issuers with a written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) to allow the office to obtain medical information relevant to the matter before the office.

(3) AVAILABILITY OF SERVICES.—The health care consumer assistance office of a State shall not discriminate in the provision of information, referrals, and services regardless of the source of the individual'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 plans, or health insurance issuers with the office and to ensure that no information is disclosed to the State agency or office without the written authorization of the individual or their personal representative in accordance with paragraph (2).

(B) CONTRACT ENTITY.—In the case of an entity that enters into a contract with a State under subsection (a)(3), the entity shall provide assurances that the entity has no conflict of interest in carrying out the activities of the office and that the entity is independent of group health plans, health insurance issuers, providers, payers, and regulators of health care.

(5) SUBCONTRACTS.—The health care consumer assistance office of a State may carry out activities and provide services through contracts entered into with 1 or more nonprofit entities so long as the office can demonstrate that all of the requirements of this section are complied with by the office.

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

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

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

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If—

(1) a health insurance issuer providing health insurance coverage in connection with a group health plan offers to enrollees health insurance coverage which provides for coverage of services (including physician pathology services) only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, or

(2) a group health plan offers to participants or beneficiaries health benefits which provide for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the plan to provide such services,

then the issuer or plan shall also offer or arrange to be offered to such enrollees, participants, or beneficiaries (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage or health benefits which provide for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless such enrollees, participants, or beneficiaries are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer or group health plan for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee, participant, or beneficiary unless it is paid by the health plan sponsor or group health plan through agreement with the health insurance issuer.

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

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

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

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

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

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider 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 section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

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

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of

the Social Security Act (42 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 114. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

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

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

(A) to require the coverage under a group health plan or health insurance coverage of benefits 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) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a nonparticipating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan and a health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition.

(B) ONGOING SPECIAL CONDITION DEFINED.—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 specialty 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 primary 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

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

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

(d) SPECIALIST DEFINED.—For purposes of this section, the term ''specialist'' means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, and a health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan and a health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

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

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

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

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

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

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

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

SEC. 117. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in paragraph (e)(4)), or

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

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

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

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

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

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with

respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

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

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

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

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

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

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

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

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

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

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

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

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

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

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

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

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

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' or ''provider'' means—

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

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

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

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section 114(b)(2)(B)).

(4) TERMINATED.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

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

(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary;

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

(3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

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

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

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

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

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

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

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

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

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

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

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

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation—

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

(i) the National Institutes of Health;

(ii) a cooperative group or center of the National Institutes of Health, including a qualified nongovernmental research entity to which the National Cancer Institute has awarded a center support grant;

(iii) either of the following if the conditions described in paragraph (2) are met—

(I) the Department of Veterans Affairs;

(II) the Department of Defense; or

(B) approved by the Food and Drug Administration.

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

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

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

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to 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.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

(A) a mastectomy;

(B) a lumpectomy; or

(C) a lymph node dissection for the treatment of breast cancer.

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

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage, may not modify the terms and conditions of coverage based on the determination by a participant, beneficiary, or enrollee to request less than the minimum coverage required under subsection (a).

(c) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan or coverage with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan or issuer.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(d) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage, may not—

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant, beneficiary, or enrollee in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

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

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) REQUIREMENT.—

(1) DISCLOSURE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure to participants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year; and

(iii) of information relating to any material reduction to the benefits or information described in such subsection or subsection (c), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect.

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

(i) jointly to each participant, beneficiary, and enrollee who reside at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

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

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

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

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

(C) any specific exclusions or express limitations of benefits described in section 104(d)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

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

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

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

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

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

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

(5) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients.

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

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

(8) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(9) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 112(b)(2) and the right to timely access to specialists care under section 114 if such section applies.

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

(11) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(12) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(13) CLAIMS AND APPEALS.—A description of the plan or issuer's rules and procedures pertaining to claims and appeals, a description of the rights (including deadlines for exercising rights) of participants, beneficiaries, and enrollees under subtitle A in obtaining covered benefits, filing a claim for benefits, and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(14) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(15) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

(16) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants, beneficiaries, and enrollees with communication disabilities and a description of how to access these items or services.

(17) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants, beneficiaries, and enrollees.

(18) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (17)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

(19) AVAILABILITY OF ADDITIONAL INFORMATION.—A statement that the information described in subsection (c), and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request.

(20) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each such decisionmaker.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee shall include for each option available under a group health plan or health insurance coverage the following:

(1) STATUS OF PROVIDERS.—The State licensure status of the plan or issuer's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

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

(3) PRESCRIPTION DRUGS.—Information about whether a specific prescription medication is included in the formulary of the plan or issuer, if the plan or issuer uses a defined formulary.

(4) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

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

(d) MANNER OF DISCLOSURE.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(e) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; and

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

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

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

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of

any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan, and a health insurance issuer with respect to health insurance coverage, shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

(1) as requiring the coverage under a group health plan or health insurance coverage of a particular benefit or service or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

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

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

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

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

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner that is no less protective than the provisions of section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2)).

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

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

(1) IN GENERAL.—A group health plan and a health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

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

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

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

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

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

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

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

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

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

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

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

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

(2) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

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

(10) TERMS AND CONDITIONS.—The term ''terms and conditions'' includes, with respect to a group health plan or health insurance coverage, requirements imposed under this title with respect to the plan or coverage.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

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

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

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this Act (except in the case of other substantially compliant requirements), in applying the requirements of this title under section 2707 and 2753 (as applicable) of the Public Health Service Act (as added by title II), subject to subsection (a)(2)—

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

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' 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 with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

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

(3) APPROVAL.—

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

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

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

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

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved with respect to the patient protection involved.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

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

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

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

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

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this Act become effective, as provided for in section 601, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

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

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

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

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

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

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

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

(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

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

(C) allows access to any provider that is lawfully authorized to provide the covered services and that agrees to accept the terms and conditions of payment established under the plan or by the issuer; and

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

SEC. 154. TREATMENT OF EXCEPTED BENEFITS.

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

(b) COVERAGE OF CERTAIN LIMITED SCOPE PLANS.—Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act, section 714 of the Employee Retirement Income Security Act of 1974, and section 9813 of the Internal Revenue Code of 1986, the following sections shall be deemed not to apply:

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

(2) Section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974.

(3) Section 9832(c)(2)(A) of the Internal Revenue Code of 1986.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services, Labor, and the Treasury shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

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

SEC. 157. PRESERVATION OF PROTECTIONS.

(a) IN GENERAL.—The rights under this Act (including the right to maintain a civil action and any other rights under the amendments made by this Act) may not be waived, deferred, or lost pursuant to any agreement not authorized under this Act.

(b) EXCEPTION.—Subsection (a) shall not apply to an agreement providing for arbitration or participation in any other nonjudicial procedure to resolve a dispute if the agreement is entered into knowingly and voluntarily by the parties involved after the dispute has arisen or is pursuant to the terms of a collective bargaining agreement. Nothing in this subsection shall be construed to permit the waiver of the requirements of sections 103 and 104 (relating to internal and external review).

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.

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

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

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

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

''SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

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

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO FEDERAL HEALTH INSURANCE PROGRAMS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that enrollees in Federal health insurance programs should have the same rights and privileges as those afforded under title I and under the amendments made by title IV to participants and beneficiaries under group health plans.

(b) CONFORMING FEDERAL HEALTH INSURANCE PROGRAMS.—It is the sense of Congress that the President should require, by executive order, the Federal official with authority over each Federal health insurance program, to the extent feasible, to take such steps as are necessary to implement the rights and privileges described in subsection (a) with respect to such program.

(c) GAO REPORT ON ADDITIONAL STEPS REQUIRED.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on statutory changes that are required to implement such rights and privileges in a manner that is consistent with the missions of the Federal health insurance programs and that avoids unnecessary duplication or disruption of such programs.

(d) FEDERAL HEALTH INSURANCE PROGRAM.—In this section, the term ''Federal health insurance program'' means a Federal program that provides creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act) and includes a health program of the Department of Veterans Affairs.

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.

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

''SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Patient Protection Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Patient Protection Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 111 (relating to consumer choice option).

''(B) Section 112 (relating to choice of health care professional).

''(C) Section 113 (relating to access to emergency care).

''(D) Section 114 (relating to timely access to specialists).

''(E) Section 115 (relating to patient access to obstetrical and gynecological care).

''(F) Section 116 (relating to access to pediatric care).

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

''(H) Section 118 (relating to access to needed prescription drugs).

''(I) Section 119 (relating to coverage for individuals participating in approved clinical trials).

''(J) Section 120 (relating to required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations).

''(K) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121 of the Bipartisan Patient Protection Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) INTERNAL APPEALS.—With respect to the internal appeals process required to be established under section 103 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 104 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections of the Bipartisan Patient Protection Act, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) TREATMENT OF SUBSTANTIALLY COMPLIANT STATE LAWS.—For purposes of applying this subsection in connection with health insurance coverage, any reference in this subsection to a requirement in a section or other provision in the Bipartisan Patient Protection Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 152(c) of such Act) with the requirement in such section or other provisions.

''(8) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Patient Protection Act, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Patient Protection Act may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title. In order to reduce duplication and clarify the rights of participants and beneficiaries with respect to information that is required to be provided, such regulations shall coordinate the information disclosure requirements under section 121 of the Bipartisan Patient Protection Act with the reporting and disclosure requirements imposed under part 1, so long as such coordination does not result in any reduction in the information that would otherwise be provided to participants and beneficiaries.''.

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

''(b) In the case of a group health plan (as defined in section 733), compliance with the requirements of subtitle A of title I of the Bipartisan Patient Protection Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial, shall be deemed compliance with subsection (a) with respect to such claims denial.''.

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

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

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 402. AVAILABILITY OF CIVIL REMEDIES.

(a) AVAILABILITY OF FEDERAL CIVIL REMEDIES IN CASES NOT INVOLVING MEDICALLY REVIEWABLE DECISIONS.—

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

''(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

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

''(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer, or plan sponsor, upon consideration of a claim for benefits of a participant or beneficiary under section 102 of the Bipartisan Patient Protection Act (relating to procedures for initial claims for benefits and prior authorization determinations) or upon review of a denial of such a claim under section 103 of such Act (relating to internal appeal of a denial of a claim for benefits), fails to exercise ordinary care in making a decision—

''(i) regarding whether an item or service is covered under the terms and conditions of the plan or coverage,

''(ii) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage), or

''(iii) as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage, and

''(B) such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary,

such plan, plan sponsor, or issuer shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages (but not exemplary or punitive damages) in connection with such personal injury or death.

''(2) CAUSE OF ACTION MUST NOT INVOLVE MEDICALLY REVIEWABLE DECISION.—

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

''(B) MEDICALLY REVIEWABLE DECISION.—For purposes of this subsection, the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act (relating to medically reviewable decisions).

''(3) LIMITATION REGARDING CERTAIN TYPES OF ACTIONS SAVED FROM PREEMPTION OF STATE LAW.—A cause of action is not established under paragraph (1)(A) in connection with a failure described in paragraph (1)(A) to the extent that a cause of action under State law (as defined in section 514(c)) for such failure would not be preempted under section 514.

''(4) DEFINITIONS AND RELATED RULES.—For purposes of this subsection.—

''(A) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care,

skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

''(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(C) CLAIM FOR BENEFITS; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' have the meanings provided such terms in section 102(e) of the Bipartisan Patient Protection Act.

''(D) TERMS AND CONDITIONS.—The term 'terms and conditions' includes, with respect to a group health plan or health insurance coverage, requirements imposed under title I of the Bipartisan Patient Protection Act.

''(E) TREATMENT OF EXCEPTED BENEFITS.—Under section 154(a) of the Bipartisan Patient Protection Act, the provisions of this subsection and subsection (a)(1)(C) do not apply to certain excepted benefits.

''(5) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1)(A) does not authorize a cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment).

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) under paragraph (1)(A), to the extent there was direct participation by the employer or other plan sponsor (or employee) in the decision of the plan under section 102 of the Bipartisan Patient Protection Act upon consideration of a claim for benefits or under section 103 of such Act upon review of a denial of a claim for benefits.

''(C) DIRECT PARTICIPATION.—

''(i) IN GENERAL.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in paragraph (1)(A), the actual making of such decision or the actual exercise of control in making such decision.

''(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 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

''(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

''(iii) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

''(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

''(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions 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 responsibility) that is self-insured and self-administered.

''(6) EXCLUSION OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.—

''(A) IN GENERAL.—No treating physician or other treating health care professional of the participant or beneficiary, and no person acting under the direction of such a physician or health care professional, shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(B) DEFINITIONS.—For purposes of subparagraph (A)—

''(i) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(ii) NON-MEDICALLY REVIEWABLE DUTY.—The term 'non-medically reviewable duty' means a duty the discharge of which does not include the making of a medically reviewable decision.

''(7) EXCLUSION OF HOSPITALS.—No treating hospital of the participant or beneficiary shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty (as defined in paragraph (6)(B)(ii)) of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(8) RULE OF CONSTRUCTION RELATING TO EXCLUSION FROM LIABILITY OF PHYSICIANS, HEALTH CARE PROFESSIONALS, AND HOSPITALS.—Nothing in paragraph (6) or (7) shall be construed to limit the liability (whether direct or vicarious) of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS 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 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 Bipartisan Patient Protection Act 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 ⅓ 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 DISTRICT COURT.—The last Federal district court in which the action was pending upon the final disposition, including all appeals, of the action shall have jurisdiction to review the attorney's fee to ensure that the fee is a reasonable one.

''(12) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after 3 years after the later of—

''(A) the date on which the plaintiff first knew, or reasonably should have known, of the personal injury or death resulting from the failure described in paragraph (1), or

''(B) the date as of which the requirements of paragraph (9) are first met.

''(13) TOLLING PROVISION.—The statute of limitations for any cause of action arising under State law relating to a denial of a claim for benefits that is the subject of an action brought in Federal court under this subsection shall be tolled until such time as the Federal court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the Federal court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

''(14) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

''(15) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not include making decisions on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(16) EXCLUSION OF HEALTH INSURANCE AGENTS.—Paragraph (1) does not apply with respect to a person whose sole involvement with the group health plan is providing advice or administrative services to the employer or other plan sponsor relating to the selection of health insurance coverage offered in connection with the plan.

''(17) NO EFFECT ON STATE LAW.—No provision of State law (as defined in section 514(c)(1)) shall be treated as superseded or otherwise altered, amended, modified, invalidated, or impaired by reason of the provisions of subsection (a)(1)(C) and this subsection.

''(18) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Notwithstanding the direct participation (as defined in paragraph (5)(C)(i)) of an employer or plan sponsor, in any case in which there is (or is deemed under subparagraph (B) to be) a designated decisionmaker under subparagraph (B) that meets the requirements of subsection (o)(1) for an employer or other plan sponsor—

''(i) all liability of such employer or plan sponsor involved (and any employee of such employer or sponsor acting within the scope of employment) under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker, and

''(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or sponsor (or employee) in the action and may not raise any defense that the employer or sponsor (or employee) could not raise if such a decisionmaker were not so deemed.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (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.).

''(19) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures; or

''(ii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(20) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(o) REQUIREMENTS FOR DESIGNATED DECISIONMAKERS OF GROUP HEALTH PLANS.—

''(1) IN GENERAL.—For purposes of subsection (n)(18) and section 514(d)(9), a designated decisionmaker meets the requirements of this paragraph with respect to any participant or beneficiary if—

''(A) such designation is in such form as may be prescribed in regulations of the Secretary,

''(B) the designated decisionmaker—

''(i) meets the requirements of paragraph (2),

''(ii) assumes unconditionally all liability of the employer or plan sponsor involved (and any employee of such employer or sponsor acting within the scope of employment) either arising under subsection (n) or arising in a cause of action permitted under section 514(d) in connection with actions (and failures to act) of the employer or plan sponsor (or employee) occurring during the period in which the designation under subsection (n)(18) or section 514(d)(9) is in effect relating to such participant and beneficiary,

''(iii) agrees to be substituted for the employer or plan sponsor (or employee) in the action and not to raise any defense with respect to such liability that the employer or plan sponsor (or employee) may not raise, and

''(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant 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 Bipartisan Patient Protection Act.

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 sponsor or named fiduciary and to the Secretary upon designation under subsection (n)(18)(B) or section 517(d)(9)(B) and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

''(B) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a single health insurance issue, such issuer is the only entity that may be qualified under this paragraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

''(3) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of paragraph (2)(A), the requirements relating to the financial obligation of an entity for liability shall include—

''(A) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this part; or

''(B) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this part.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this paragraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

''(4) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d) may not be designated as a designated decisionmaker under this subsection with respect to such participant or beneficiary.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking ''or'' at the end of subparagraph (A);

(B) in subparagraph (B), by striking ''plan;'' and inserting ''plan, or''; and

(C) by adding at the end the following new subparagraph:

''(C) for the relief provided for in subsection (n) of this section.''.

(b) RULES RELATING TO ERISA PREEMPTION.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following new subsections:

''(d) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION UNDER STATE LAW INVOLVING MEDICALLY REVIEWABLE DECISION.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to supersede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) against the plan, the plan sponsor, any health insurance issuer offering health insurance coverage in connection with the plan, or any managed care entity in connection with the plan to recover damages resulting from personal injury or for wrongful death if such cause of action arises by reason of a medically reviewable decision.

''(B) MEDICALLY REVIEWABLE DECISION.—For purposes of subparagraph (A), the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act (relating to medically reviewable decisions).

''(C) LIMITATION ON PUNITIVE DAMAGES.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), with respect to a cause of action described in subparagraph (A) brought with respect to a participant or beneficiary, State law is superseded insofar as it provides any punitive, exemplary, or similar damages if, as of the time of the personal injury or death, all the requirements of the following sections of the Bipartisan Patient Protection Act were satisfied with respect to the participant or beneficiary:

''(I) Section 102 (relating to procedures for initial claims for benefits and prior authorization determinations).

''(II) Section 103 of such Act (relating to internal appeals of claims denials).

''(III) Section 104 of such Act (relating to independent external appeals procedures).

''(ii) EXCEPTION FOR CERTAIN ACTIONS FOR WRONGFUL DEATH.—Clause (i) shall not apply with respect to an action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such an action which are only punitive or exemplary in nature.

''(iii) EXCEPTION FOR WILLFUL OR WANTON DISREGARD FOR THE RIGHTS OR SAFETY OF OTHERS.—Clause (i) shall not apply with respect to any cause of action described in subparagraph (A) if, in such action, the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with willful or wanton disregard for the rights or safety of others was a proximate cause of the personal injury or wrongful death that is the subject of the action.

''(2) DEFINITIONS AND RELATED RULES.—For purposes of this subsection and subsection (e)—

''(A) TREATMENT OF EXCEPTED BENEFITS.—Under section 154(a) of the Bipartisan Patient Protection Act, the provisions of this subsection do not apply to certain excepted benefits.

''(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(C) CLAIM FOR BENEFIT; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' shall have the meaning provided such terms under section 102(e) of the Bipartisan Patient Protection Act.

''(D) MANAGED CARE ENTITY.—

''(i) IN GENERAL.—The term 'managed care entity' means, in connection with a group health plan and subject to clause (ii), any entity that is involved in determining the manner in which or the extent to which items or services (or reimbursement therefor) are to be provided as benefits under the plan.

''(ii) TREATMENT OF TREATING PHYSICIANS, OTHER TREATING HEALTH CARE PROFESSIONALS, AND TREATING HOSPITALS.—Such term does not include a treating physician or other treating health care professional (as defined in section 502(n)(6)(B)(i)) of the participant or beneficiary and also does not include a treating hospital insofar as it is acting solely in the capacity of providing treatment or care to the participant or beneficiary. Nothing in the preceding sentence shall be construed to preempt vicarious liability of any plan, plan sponsor, health insurance issuer, or managed care entity.

''(3) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1) does not apply with respect to—

''(i) any cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

''(ii) a right of recovery, indemnity, or contribution by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action to which paragraph (1) applies.

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), paragraph (1) applies with respect to any cause of action that is brought by a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment) if such cause of action arises by reason of a medically reviewable decision, to the extent that there was direct participation by the employer or other plan sponsor (or employee) in the decision.

''(C) DIRECT PARTICIPATION.—

''(i) DIRECT PARTICIPATION IN DECISIONS.—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 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

''(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

''(iv) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

''(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

''(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions of the plan for that or any other participant or beneficiary (or any group of participants or beneficiaries).

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—Except as provided in subparagraph (D), a cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102, 103, and 104 of the Bipartisan Patient Protection Act (if applicable) have been exhausted.

''(B) LATE MANIFESTATION OF INJURY.—

''(i) IN GENERAL.—A participant or beneficiary shall not be precluded from pursuing a review under section 104 of the Bipartisan Patient Protection Act regarding an injury that such participant or beneficiary has experienced if the external review entity first

determines that the injury of such participant or beneficiary is a late manifestation of an earlier injury.

''(ii) DEFINITION.—In this subparagraph, the term 'late manifestation of an earlier injury' means an injury sustained by the participant or beneficiary which was not known, and should not have been known, by such participant or beneficiary by the latest date that the requirements of subparagraph (A) should have been met regarding the claim for benefits which was denied.

''(C) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(D) FAILURE TO REVIEW.—

''(i) IN GENERAL.—If the external review entity fails to make a determination within the time required under section 104(e)(1)(A)(i), a participant or beneficiary may bring an action under section 514(d) after 10 additional days after the date on which such time period has expired and the filing of such action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to 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), a participant or beneficiary may bring an action under this subsection 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 section 104(e)(1)(A)(ii).

''(E) RECEIPT OF BENEFITS DURING APPEALS 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 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.

''(F) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

''(5) TOLLING PROVISION.—The statute of limitations for any cause of action arising under section 502(n) relating to a denial of a claim for benefits that is the subject of an action brought in State court shall be tolled until such time as the State court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the State court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

''(6) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not include making decisions on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) saving from preemption a cause of action under State law for the failure to provide a benefit for an item or service which is specifically excluded under the group health plan involved, except to the extent that—

''(i) the application or interpretation of the exclusion involves a determination described in section 104(d)(2) of the Bipartisan Patient Protection Act, or

''(ii) the provision of the benefit for the item or service is required under Federal law or under applicable State law consistent with subsection (b)(2)(B);

''(B) preempting a State law which requires an affidavit or certificate of merit in a civil action;

''(C) affecting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A); or

''(D) affecting a cause of action under State law other than a cause of action described in paragraph (1)(A).

''(8) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action described in paragraph (1)(A).

''(9) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to any cause of action described in paragraph (1)(A) under State law insofar as such cause of action provides for liability with respect to a participant or beneficiary of an employer or plan sponsor (or an employee of such employer or sponsor acting within the scope of employment), if with respect to the employer or plan sponsor there is (or is deemed under subparagraph (B) to be) a designated decisionmaker that meets the requirements of section 502(o)(1) with respect to such participant or beneficiary. Such paragraph (1) shall apply with respect to any cause of action described in paragraph (1)(A) under State law against the designated decisionmaker of such employer or other plan sponsor with respect to the participant or beneficiary.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (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, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(11) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(12) CHOICE OF LAW.—A cause of action brought under paragraph (1) shall be governed by the law (including choice of law rules) of the State in which the plaintiff resides.

''(13) 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 under paragraph (1) shall not exceed ⅓ 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 under paragraph (1) 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 (whether the liability is direct or vicarious) based upon such a State law,

''(2) superseding any State law permitted under section 152(b)(1)(A) of the Bipartisan Patient Protection Act, or

''(3) affecting any applicable State law with respect to limitations on monetary damages.

''(f) NO RIGHT OF ACTION FOR RECOVERY, INDEMNITY, OR CONTRIBUTION BY ISSUERS AGAINST TREATING HEALTH CARE PROFESSIONALS AND TREATING HOSPITALS.—In the case of any care provided, or any treatment decision made, by the treating health care professional or the treating hospital of a participant or beneficiary under a group health plan which consists of medical care provided under such plan, any cause of action under State law against the treating health care professional or the treating hospital by the plan or a health insurance issuer providing health insurance coverage in connection with the plan for recovery, indemnity, or contribution in connection with such care (or any medically reviewable decision made in connection with such care) or such treatment decision is superseded.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the applicable effective under section 601.

SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402, is further amended by adding at the end the following:

''(p) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.''.

SEC. 404. LIMITATIONS ON ACTIONS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 402(a)) is amended further by adding at the end the following new subsection:

''(q) LIMITATIONS ON ACTIONS RELATING TO GROUP HEALTH PLANS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 101, subtitle B, or subtitle D of title I of the Bipartisan Patient Protection Act (as incorporated under section 714).

''(2) CERTAIN ACTIONS ALLOWABLE.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 101, 113, 114, 115, 116, 117, 118(a)(3), 119, or 120 of the Bipartisan Patient Protection Act (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) OTHER PROVISIONS UNAFFECTED.—Nothing in this subsection shall be construed as affecting subsections (a)(1)(C) and (n) or section 514(d).

''(4) ENFORCEMENT BY SECRETARY UNAFFECTED.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

SEC. 405. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following new section:

''SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

SEC. 406. SENSE OF THE SENATE CONCERNING THE IMPORTANCE OF CERTAIN UNPAID SERVICES.

It is the sense of the Senate that the court should consider the loss of a nonwage earning spouse or parent as an economic loss for the purposes of this section. Furthermore, the court should define the compensation for the loss not as minimum services, but, rather, in terms that fully compensate for the true and whole replacement cost to the family.

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 Bipartisan Patient Protection Act (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.''.

SEC. 502. CONFORMING ENFORCEMENT FOR WOMEN'S HEALTH AND CANCER RIGHTS.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 501, is further amended—

(1) in the table of sections, by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Standard relating to women's health and cancer rights.'';

and

(2) by inserting after section 9813 the following:

''SEC. 9814. STANDARD RELATING TO WOMEN'S HEALTH AND CANCER RIGHTS.

''The provisions of section 713 of the Employee Retirement Income Security Act of 1974 (as in effect as of the date of the enactment of this section) shall apply to group health plans as if included in this subchapter.''.

Subtitle B—Health Care Coverage Access Tax Incentives

SEC. 511. EXPANDED AVAILABILITY OF ARCHER MSAS.

(a) EXTENSION OF PROGRAM.—Paragraphs (2) and (3)(B) of section 220(i) of the Internal Revenue Code of 1986 (defining cut-off year) are each amended by striking ''2002'' each place it appears and inserting ''2004''.

(b) INCREASE IN NUMBER OF PERMITTED ACCOUNT PARTICIPANTS.—

(1) IN GENERAL.—Subsection (j) of section 220 of such Code is amended by redesignating paragraphs (3), (4), and (5) as paragraphs (4), (5), and (6) and by inserting after paragraph (2) the following new paragraph:

''(3) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR YEARS AFTER 2001.—

''(A) IN GENERAL.—The numerical limitation for any year after 2001 is exceeded if the sum of—

''(i) the number of Archer MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

''(ii) the Secretary's estimate (determined on the basis of the returns described in clause (i)) of the number of Archer MSA returns for such taxable years which will be filed after such date, exceeds 1,000,000. For purposes of the preceding sentence, the term 'Archer MSA return' means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

''(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for any year after 2001 is also exceeded if the sum of—

''(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

''(ii) the product of 2.5 and the number of medical savings accounts established during the portion of such year preceding July 1 (based on the reports required under paragraph (5)) for taxable years beginning in such year,

exceeds 1,000,000''.

(2) CONFORMING AMENDMENTS.—

(A) Clause (ii) of section 220(j)(2)(B) of such Code is amended by striking ''paragraph (4)'' and inserting ''paragraph (5)''.

(B) Subparagraph (A) of section 220(j)(4) of such Code is amended by striking ''and 2001'' and inserting ''2001, 2002, and 2003''.

(c) INCREASE IN SIZE OF ELIGIBLE EMPLOYERS.—Subparagraph (A) of section 220(c)(4) of such Code is amended by striking ''50 or fewer employees'' and inserting ''100 or fewer employees''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(e) GAO STUDY.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the impact of Archer MSAs on the cost of conventional insurance (especially in those areas where there are higher numbers of such accounts) and on adverse selection and health care costs.

SEC. 512. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 513. CREDIT FOR HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following:

''SEC. 45E. SMALL BUSINESS HEALTH INSURANCE EXPENSES.

''(a) GENERAL RULE.—For purposes of section 38, in the case of a small employer, the health insurance credit determined under this section for the taxable year is an amount equal to the applicable percentage of the expenses paid by the taxpayer during the taxable year for health insurance coverage for such year provided under a new health plan for employees of such employer.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage is—

''(1) in the case of insurance purchased as a member of a qualified health benefit purchasing coalition (as defined in section 9841), 30 percent, and

''(2) in the case of insurance not described in paragraph (1), 20 percent.

''(c) LIMITATIONS.—

''(1) PER EMPLOYEE DOLLAR LIMITATION.—The amount of expenses taken into account under subsection (a) with respect to any employee for any taxable year shall not exceed—

''(A) $2,000 in the case of self-only coverage, and

''(B) $5,000 in the case of family coverage. In the case of an employee who is covered by a new health plan of the employer for only a portion of such taxable year, the limitation under the preceding sentence shall be an amount which bears the same ratio to such limitation (determined without regard to this sentence) as such portion bears to the entire taxable year.

''(2) PERIOD OF COVERAGE.—Expenses may be taken into account under subsection (a) only with respect to coverage for the 4-year period beginning on the date the employer establishes a new health plan.

''(d) DEFINITIONS.—For purposes of this section—

''(1) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1).

''(2) NEW HEALTH PLAN.—

''(A) IN GENERAL.—The term 'new health plan' means any arrangement of the employer which provides health insurance coverage to employees if—

''(i) such employer (and any predecessor employer) did not establish or maintain such arrangement (or any similar arrangement) at any time during the 2 taxable years ending prior to the taxable year in which the credit under this section is first allowed, and

''(ii) such arrangement provides health insurance coverage to at least 70 percent of the qualified employees of such employer.

''(B) QUALIFIED EMPLOYEE.—

''(i) IN GENERAL.—The term 'qualified employee' means any employee of an employer if the annual rate of such employee's compensation (as defined in section 414(s)) exceeds $10,000.

''(ii) TREATMENT OF CERTAIN EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

''(3) SMALL EMPLOYER.—The term 'small employer' has the meaning given to such term by section 4980D(d)(2); except that only qualified employees shall be taken into account.

''(e) SPECIAL RULES.—

''(1) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

''(2) AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred pursuant to a salary reduction arrangement shall be taken into account under subsection (a).

''(f) TERMINATION.—This section shall not apply to expenses paid or incurred by an employer with respect to any arrangement established on or after January 1, 2010.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of such Code (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', plus'', and by adding at the end the following:

''(14) in the case of a small employer (as defined in section 45E(d)(3)), the health insurance credit determined under section 45E(a).''.

(c) NO CARRYBACKS.—Subsection (d) of section 39 of such Code (relating to carryback and carryforward of unused credits) is amended by adding at the end the following:

''(10) NO CARRYBACK OF SECTION 45E CREDIT BEFORE EFFECTIVE DATE.—No portion of the unused business credit for any taxable year which is attributable to the employee health insurance expenses credit determined under section 45E may be carried back to a taxable year ending before the date of the enactment of section 45E.''.

(d) DENIAL OF DOUBLE BENEFIT.—Section 280C of such Code is amended by adding at the end the following new subsection:

''(d) CREDIT FOR SMALL BUSINESS HEALTH INSURANCE EXPENSES.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the expenses (otherwise allowable as a deduction) taken into account in determining the credit under section 45E for the taxable year which is equal to the amount of the credit determined for such taxable year under section 45E(a).

''(2) CONTROLLED GROUPS.—Persons treated as a single employer under subsection (a) or (b) of section 52 shall be treated as 1 person for purposes of this section.''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding at the end the following:

''Sec. 45E. Small business health insurance expenses.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2001, for arrangements established after the date of the enactment of this Act.

SEC. 514. CERTAIN GRANTS BY PRIVATE FOUNDATIONS TO QUALIFIED HEALTH BENEFIT PURCHASING COALITIONS.

(a) IN GENERAL.—Section 4942 of the Internal Revenue Code of 1986 (relating to taxes on failure to distribute income) is amended by adding at the end the following:

''(k) CERTAIN QUALIFIED HEALTH BENEFIT PURCHASING COALITION DISTRIBUTIONS.—

''(1) IN GENERAL.—For purposes of subsection (g), sections 170, 501, 507, 509, and 2522, and this chapter, a qualified health benefit purchasing coalition distribution by a private foundation shall be considered to be a distribution for a charitable purpose.

''(2) QUALIFIED HEALTH BENEFIT PURCHASING COALITION DISTRIBUTION.—For purposes of paragraph (1)—

''(A) IN GENERAL.—The term 'qualified health benefit purchasing coalition distribution' means any amount paid or incurred by a private foundation to or on behalf of a qualified health benefit purchasing coalition (as defined in section 9841) for purposes of payment or reimbursement of amounts paid or incurred in connection with the establishment and maintenance of such coalition.

''(B) EXCLUSIONS.—Such term shall not include any amount used by a qualified health benefit purchasing coalition (as so defined)—

''(i) for the purchase of real property,

''(ii) as payment to, or for the benefit of, members (or employees or affiliates of such members) of such coalition, or

''(iii) for any expense paid or incurred more than 48 months after the date of establishment of such coalition.

''(3) TERMINATION.—This subsection shall not apply—

''(A) to qualified health benefit purchasing coalition distributions paid or incurred after December 31, 2009, and

''(B) with respect to start-up costs of a coalition which are paid or incurred after December 31, 2010.''.

(b) QUALIFIED HEALTH BENEFIT PURCHASING COALITION.—

(1) IN GENERAL.—Chapter 100 of such Code (relating to group health plan requirements) is amended by adding at the end the following new subchapter:

''Subchapter D—Qualified Health Benefit Purchasing Coalition

''Sec. 9841. Qualified health benefit purchasing coalition.

''SEC. 9841. QUALIFIED HEALTH BENEFIT PURCHASING COALITION.

''(a) IN GENERAL.—A qualified health benefit purchasing coalition is a private not-for-profit corporation which—

''(1) sells health insurance through State licensed health insurance issuers in the State in which the employers to which such coalition is providing insurance are located, and

''(2) establishes to the Secretary, under State certification procedures or other procedures as the Secretary may provide by regulation, that such coalition meets the requirements of this section.

''(b) BOARD OF DIRECTORS.—

''(1) IN GENERAL.—Each purchasing coalition under this section shall be governed by a Board of Directors.

''(2) ELECTION.—The Secretary shall establish procedures governing election of such Board.

''(3) MEMBERSHIP.—The Board of Directors shall—

''(A) be composed of representatives of the members of the coalition, in equal number,

including small employers and employee representatives of such employers, but

''(B) not include other interested parties, such as service providers, health insurers, or insurance agents or brokers which may have a conflict of interest with the purposes of the coalition.

''(c) MEMBERSHIP OF COALITION.—

''(1) IN GENERAL.—A purchasing coalition shall accept all small employers residing within the area served by the coalition as members if such employers request such membership.

''(2) OTHER MEMBERS.—The coalition, at the discretion of its Board of Directors, may be open to individuals and large employers.

''(3) VOTING.—Members of a purchasing coalition shall have voting rights consistent with the rules established by the State.

''(d) DUTIES OF PURCHASING COALITIONS.—Each purchasing coalition shall—

''(1) enter into agreements with small employers (and, at the discretion of its Board, with individuals and other employers) to provide health insurance benefits to employees and retirees of such employers,

''(2) where feasible, enter into agreements with 3 or more unaffiliated, qualified licensed health plans, to offer benefits to members,

''(3) offer to members at least 1 open enrollment period of at least 30 days per calendar year,

''(4) serve a significant geographical area and market to all eligible members in that area, and

''(5) carry out other functions provided for under this section.

''(e) LIMITATION ON ACTIVITIES.—A purchasing coalition shall not—

''(1) perform any activity (including certification or enforcement) relating to compliance or licensing of health plans,

''(2) assume insurance or financial risk in relation to any health plan, or

''(3) perform other activities identified by the State as being inconsistent with the performance of its duties under this section.

''(f) ADDITIONAL REQUIREMENTS FOR PURCHASING COALITIONS.—As provided by the Secretary in regulations, a purchasing coalition shall be subject to requirements similar to the requirements of a group health plan under this chapter.

''(g) RELATION TO OTHER LAWS.—

''(1) PREEMPTION OF STATE FICTITIOUS GROUP LAWS.—Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for health insurance coverage are preempted to the extent such requirements impede the establishment and operation of qualified health benefit purchasing coalitions.

''(2) ALLOWING SAVINGS TO BE PASSED THROUGH.—Any State law that prohibits health insurance issuers from reducing premiums on health insurance coverage sold through a qualified health benefit purchasing coalition to reflect administrative savings is preempted. This paragraph shall not be construed to preempt State laws that impose restrictions on premiums based on health status, claims history, industry, age, gender, or other underwriting factors.

''(3) NO WAIVER OF HIPAA REQUIREMENTS.—Nothing in this section shall be construed to change the obligation of health insurance issuers to comply with the requirements of title XXVII of the Public Health Service Act with respect to health insurance coverage offered to small employers in the small group market through a qualified health benefit purchasing coalition.

''(h) DEFINITION OF SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'small employer' means, with respect to any calendar year, any employer if such employer employed an average of at least 2 and not more than 50 qualified employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

''(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under paragraph (1) shall be based on the average number of qualified employees that it is reasonably expected such employer will employ on business days in the current calendar year.''.

(2) CONFORMING AMENDMENT.—The table of subchapters for chapter 100 of such Code is amended by adding at the end the following item:

''Subchapter D. Qualified health benefit purchasing coalition.''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2001.

SEC. 515. STATE GRANT PROGRAM FOR MARKET INNOVATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program (in this section referred to as the ''program'') to award demonstration grants under this section to States to allow States to demonstrate the effectiveness of innovative ways to increase access to health insurance through market reforms and other innovative means. Such innovative means may include (and are not limited to) any of the following:

(1) Alternative group purchasing or pooling arrangements, such as purchasing cooperatives for small businesses, reinsurance pools, or high risk pools.

(2) Individual or small group market reforms.

(3) Consumer education and outreach.

(4) Subsidies to individuals, employers, or both, in obtaining health insurance.

(b) SCOPE; DURATION.—The program shall be limited to not more than 10 States and to a total period of 5 years, beginning on the date the first demonstration grant is made.

(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary may not provide for a demonstration grant to a State under the program unless the Secretary finds that under the proposed demonstration grant—

(A) the State will provide for demonstrated increase of access for some portion of the existing uninsured population through a market innovation (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 population, expected cost, and the continuation after the completion of the demonstration grant period; and

(C) the Secretary determines that the demonstration grant will be used consistent with this section.

(3) FOCUS.—A demonstration grant proposal under section need not cover all uninsured individuals in a State or all health care benefits with respect to such individuals.

(d) EVALUATION.—The Secretary shall enter into a contract with an appropriate entity outside the Department of Health and Human Services to conduct an overall evaluation of the program at the end of the program period. Such evaluation shall include an analysis of improvements in access, costs, quality of care, or choice of coverage, under different demonstration grants.

(e) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Notwithstanding the previous provisions of this section, under the program the Secretary may provide for a portion of the amounts appropriated under subsection (f) (not to exceed $5,000,000) to be made available to any State for initial planning grants to permit States to develop demonstration grant proposals under the previous provisions of this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $100,000,000 for each fiscal year to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) STATE DEFINED.—For purposes of this section, the term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

TITLE VI—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 601. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (d), the amendments made by sections 201(a), 401, 403, 501, and 502 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 2002 (in this section referred to as the ''general effective date'').

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 201(a), 401, 403, 501, and 502 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (excluding any extension thereof agreed to after the date of the enactment of this Act); or

(B) the general effective date;

but shall apply not later than 1 year after the general effective date. For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Subject to subsection (d), the amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

(d) TRANSITION FOR NOTICE REQUIREMENT.—The disclosure of information required under section 121 of this Act shall first be provided pursuant to—

(1) subsection (a) with respect to a group health plan that is maintained as of the general effective date, not later than 30 days before the beginning of the first plan year to which title I applies in connection with the plan under such subsection; or

(2) subsection (b) with respect to a individual health insurance coverage that is in effect as of the general effective date, not later than 30 days before the first date as of which title I applies to the coverage under such subsection.

SEC. 602. COORDINATION IN IMPLEMENTATION.

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

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

SEC. 603. SEVERABILITY.

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. NO IMPACT ON SOCIAL SECURITY TRUST FUND.

(a) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(b) TRANSFERS.—

(1) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this Act has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such Act.

SEC. 702. CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking ''2003'' and inserting ''2011, except that fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006''.

SEC. 703. FISCAL YEAR 2002 MEDICARE PAYMENTS.

Notwithstanding any other provision of law, any letter of credit under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that would otherwise be sent to the Treasury or the Federal Reserve Board on September 30, 2002, by a carrier with a contract under section 1842 of that Act (42 U.S.C. 1395u) shall be sent on October 1, 2002.

SEC. 704. SENSE OF SENATE WITH RESPECT TO PARTICIPATION IN CLINICAL TRIALS AND ACCESS TO SPECIALTY CARE.

(a) FINDINGS.—The Senate finds the following:

(1) Breast cancer is the most common form of cancer among women, excluding skin cancers.

(2) During 2001, 182,800 new cases of female invasive breast cancer will be diagnosed, and 40,800 women will die from the disease.

(3) In addition, 1,400 male breast cancer cases are projected to be diagnosed, and 400 men will die from the disease.

(4) Breast cancer is the second leading cause of cancer death among all women and the leading cause of cancer death among women between ages 40 and 55.

(5) This year 8,600 children are expected to be diagnosed with cancer.

(6) 1,500 children are expected to die from cancer this year.

(7) There are approximately 333,000 people diagnosed with multiple sclerosis in the United States and 200 more cases are diagnosed each week.

(8) Parkinson's disease is a progressive disorder of the central nervous system affecting 1,000,000 in the United States.

(9) An estimated 198,100 men will be diagnosed with prostate cancer this year.

(10) 31,500 men will die from prostate cancer this year. It is the second leading cause of cancer in men.

(11) While information obtained from clinical trials is essential to finding cures for diseases, it is still research which carries the risk of fatal results. Future efforts should be taken to protect the health and safety of adults and children who enroll in clinical trials.

(12) While employers and health plans should be responsible for covering the routine costs associated with federally approved or funded clinical trials, such employers and health plans should not be held legally responsible for the design, implementation, or outcome of such clinical trials, consistent with any applicable State or Federal liability statutes.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) men and women battling life-threatening, deadly diseases, including advanced breast or ovarian cancer, should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician;

(2) an individual should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician if—

(A) that individual—

(i) has a life-threatening or serious illness for which no standard treatment is effective;

(ii) is eligible to participate in a federally approved or funded clinical trial according to the trial protocol with respect to treatment of the illness;

(B) that individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual; and

(C) either—

(i) the referring physician is a participating health care professional and has concluded that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A); or

(ii) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A);

(3) a child with a life-threatening illness, including cancer, should be allowed to participate in a federally approved or funded clinical trial if that participation meets the requirements of paragraph (2);

(4) a child with a rare cancer should be allowed to go to a cancer center capable of providing high quality care for that disease; and

(5) a health maintenance organization's decision that an in-network physician without the necessary expertise can provide care for a seriously ill patient, including a woman battling cancer, should be appealable to an independent, impartial body, and that this same right should be available to all Americans in need of access to high quality specialty care.

SEC. 705. SENSE OF THE SENATE REGARDING FAIR REVIEW PROCESS.

(a) FINDINGS.—The Senate finds the following:

(1) A fair, timely, impartial independent external appeals process is essential to any meaningful program of patient protection.

(2) The independence and objectivity of the review organization and review process must be ensured.

(3) It is incompatible with a fair and independent appeals process to allow a health maintenance organization to select the review organization that is entrusted with providing a neutral and unbiased medical review.

(4) The American Arbitration Association and arbitration standards adopted under chapter 44 of title 28, United States Code (28 U.S.C. 651 et seq.) both prohibit, as inherently unfair, the right of one party to a dispute to choose the judge in that dispute.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) every patient who is denied care by a health maintenance organization or other health insurance company should be entitled to a fair, speedy, impartial appeal to a review organization that has not been selected by the health plan;

(2) the States should be empowered to maintain and develop the appropriate process for selection of the independent external review entity;

(3) a child battling a rare cancer whose health maintenance organization has denied a covered treatment recommended by its physician should be entitled to a fair and impartial external appeal to a review organization that has not been chosen by the organization or plan that has denied the care; and

(4) patient protection legislation should not pre-empt existing State laws in States where there already are strong laws in place regarding the selection of independent review organizations.

SEC. 706. ANNUAL REVIEW.

(a) IN GENERAL.—Not later than 24 months after the general effective date referred to in section 601(a)(1), and annually thereafter for each of the succeeding 4 calendar years (or until a repeal is effective under subsection (b)), the Secretary of Health and Human Services shall request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this Act, and the amendments made by this Act, on the number of individuals in the United States with health insurance coverage.

(b) LIMITATION WITH RESPECT TO CERTAIN PLANS.—If the Secretary, in any report submitted under subsection (a), determines that more than 1,000,000 individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 402 of this Act shall be repealed effective on the date that is 12 month after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(c) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 2003 and 2004, the Secretary of Health and Human Services shall provide for such funding as the Secretary determines necessary for the conduct of the study of the National Academy of Sciences under this section.

SEC. 707. DEFINITION OF BORN-ALIVE INFANT.

(a) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

''§ 8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant

''(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person', 'human being', 'child', and 'individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

''(b) As used in this section, the term 'born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, or induced abortion.

''(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive as defined in this section.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

''8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.''.

The CHAIRMAN. No amendment is in order except those printed in House Report 107–184. Each amendment may be offered only in the order printed, may be offered only by a Member designated in the report, shall be considered read, debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

It is now in order to consider Amendment No. 1 printed in House Report 107–184.

AMENDMENT NO. 1 OFFERED BY MR. THOMAS

Mr. THOMAS. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Mr. THOMAS:

Insert before section 401 the following heading (and conform the table of contents accordingly):

Subtitle A—General Provisions

In section 301(a), insert ''subtitle A of'' before ''title IV''.

Add at the end of title IV the following new subtitle (and conform the table of contents accordingly):

Subtitle B—Association Health Plans

SEC. 421. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation, through negotiated rulemaking, a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation, through negotiated rulemaking, for continued certification of association health plans under this part.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

''(1) a plan which offered such coverage on the date of the enactment of the Bipartisan Patient Protection Act,

''(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

''(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; foodservice establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services;

transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations which the Secretary shall prescribe through negotiated rulemaking.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

''(C) CERTAIN PLANS EXCLUDED.—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of the enactment of the Bipartisan Patient Protection Act.

''(D) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation, through negotiated rulemaking, define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met;

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met; and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan; or

''(B) the plan is in existence on April 1, 2001, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

''(3) CONSTRUCTION.—A group health plan described in paragraph (2) shall only be treated as an association health plan under this part if the sponsor of the plan applies for, and obtains, certification of the plan as an association health plan under this part.

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor,

''(B) the sponsor, or

''(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Bipartisan Patient Protection Act, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

''(1) the affiliated member was an affiliated member on the date of certification under this part; or

''(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

''(i) setting contribution rates based on the claims experience of the plan; or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan

has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation through negotiated rulemaking.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(e), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

''SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage; or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions;

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

''(iii) a reserve sufficient for any other obligations of the plan; and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation, through negotiated rulemaking, provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority may by regulation, through negotiated rulemaking, provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

''(1) $500,000, or

''(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority through negotiated rulemaking, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation, through negotiated rulemaking, with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B); and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to aggregate

claims under the plan in excess of an amount or amounts specified in such contract;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

''(B) which is guaranteed renewable; and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

''(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation through negotiated rulemaking); and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe through negotiated rulemaking.

''(j) SOLVENCY STANDARDS WORKING GROUP.—

''(1) IN GENERAL.—Within 90 days after the date of the enactment of the Bipartisan Patient Protection Act, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

''(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

''(A) a representative of the National Association of Insurance Commissioners;

''(B) a representative of the American Academy of Actuaries;

''(C) a representative of the State governments, or their interests;

''(D) a representative of existing self-insured arrangements, or their interests;

''(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

''(F) a representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority through negotiated rulemaking, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe through negotiated rulemaking.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation through negotiated rulemaking, as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation through negotiated rulemaking. The applicable authority may require by regulation, through negotiated rulemaking, prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation through negotiated rulemaking such interim reports as it considers appropriate.

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation through negotiated rulemaking.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation through negotiated rulemaking) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation through negotiated rulemaking, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan;

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary through negotiated rulemaking, and applicable provisions of law;

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

''(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation through negotiated rulemaking or required by any order of the court;

''(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator;

''(2) each participant;

''(3) each participating employer; and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary through negotiated rulemaking, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Bipartisan Patient Protection Act.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

''(3) such tax is otherwise nondiscriminatory; and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage,

aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

"SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan; or

''(ii) if there if no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

''(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

''(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 806(j), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation through negotiated rulemaking.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

''(C) in the case of an association health plan in existence on the date of the enactment of the Bipartisan Patient Protection Act, a person eligible to be a member of the sponsor or one of its member associations.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144), as amended by section 142, is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (e)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (e) as subsection (f); and

(D) by inserting after subsection (d) the following new subsection:

''(e)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

(C) by adding at the end the following new clause:

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care

(within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Bipartisan Patient Protection Act shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2006, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.
''Sec. 809. Corrective actions and mandatory termination.
''Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
''Sec. 811. State assessment authority.
''Sec. 812. Definitions and rules of construction.''.

SEC. 422. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement;'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement;''.

SEC. 423. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E);''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

''(II) pay any type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations prescribed by the Secretary through negotiated rulemaking), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Bipartisan Patient Protection Act and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed by the Secretary through negotiated rulemaking that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Bipartisan Patient Protection Act; or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years; or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 424. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132), as amended by sections 141 and 143, is further amended by adding at the end the following new subsection:

''(p) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

''(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) EXCEPTION.—Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133), as amended by section 301(b), is amended by adding at the end the following new subsection:

''(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 425. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State to with which consultation is required. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 426. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 421, 424, and 425 shall take effect one year from the date of enactment. The amendments made by sections 422 and 423 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within one year from the date of enactment. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 421) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on the date of the enactment of this Act, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

Amend section 511 to read as follows (and conform the table of contents accordingly):

SEC. 511. EXPANSION OF AVAILABILITY OF ARCHER MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(1) of such Code (relating to eligible individual) is amended to read as follows:

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal

to 1/12 of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan.''.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

''(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''.

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' in clause (i) and inserting ''$1,000''; and

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) SPECIAL RULES.—In the case of the $1,000 amount in subsection (c)(2)(A)(i) and the $2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting 'calendar year 2000' for 'calendar year 1997'.

''(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

(f) PROVIDING INCENTIVES FOR PREFERRED PROVIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) PREVENTIVE CARE COVERAGE PERMITTED.—Clause (ii) of section 220(c)(2)(B) of such Code is amended by striking ''preventive care if'' and all that follows and inserting ''preventive care.''

(2) TREATMENT OF NETWORK SERVICES.—Subparagraph (B) of section 220(c)(2) of such Code is amended by adding at the end the following new clause:

''(iii) TREATMENT OF NETWORK SERVICES.—In the case of a health plan which provides benefits for services provided by providers in a network (as defined in section 161 of the Patient's Bill of Rights Act of 2001) and which would (without regard to services provided by providers outside the network) be a high deductible health plan, such plan shall not fail to be a high deductible health plan because—

''(I) the annual deductible for services provided by providers outside the network exceeds the applicable maximum dollar amount in clause (i) or (ii), or

''(II) the annual out-of-pocket expenses required to be paid for services provided by providers outside the network exceeds the applicable dollar amount in clause (iii).

The annual deductible taken into account under subsection (b)(2) with respect to a plan to which the preceding sentence applies shall be the annual deductible for services provided by providers within the network.''

(g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

The CHAIRMAN. Pursuant to House Resolution 219, the gentleman from California (Mr. THOMAS) and a Member opposed each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this amendment has two major provisions, one dealing with an attempt, since we know that the Patients' Bill of Rights and the expenses associated with the albeit appropriate and necessary structural procedure of due process and potential litigation will cost additional dollars and, therefore, will have some negative impact on the number of folks who are insured, we believe that it is necessary to go forward. That is why this amendment is offered.

This amendment contains two significant provisions that we believe will significantly enhance the opportunity to retain the insurance that is available for individuals for health insurance today and, perhaps, even enhance it based upon the creative approach in this amendment.

The first provisions are called medical savings accounts, and in honor of the former chairman of the Committee on Ways and Means, these have become known as Archer MSAs.

The problem with the Archer MSAs was that they were not permanent. They were not a viable insurance product, and notwithstanding recent polls that show that up to 90 percent of Americans believe these are necessary and appropriate, especially among that group that is the least insured with health insurance, the 18- to 29-year-olds who have that 91 percent desirability for this insurance, the structure of MSAs has been such that it does not work.

Mr. Chairman, this amendment refines medical savings accounts to produce a viable insurance product.

Mr. Chairman, I reserve the balance of my time.

Mr. THOMAS. Mr. Chairman, I ask unanimous consent to yield the balance of my time to the gentleman from Texas (Mr. SAM JOHNSON) to control the time.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

The CHAIRMAN. The gentleman from California (Mr. STARK) claims the time in opposition.

Mr. STARK. Mr. Chairman, I ask unanimous consent to allocate 10 minutes to the gentleman from New Jersey (Mr. ANDREWS).

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. STARK. Mr. Chairman, I yield 2 minutes to myself.

Mr. Chairman, this is an old dead horse which for some reason has been revived again. Medical savings accounts have not worked in the private market and did not work when they were offered to Medicare beneficiaries. They did not sell one policy under Medicare. This provision comes with a price tag of nearly $5 billion over 10 years, and all that can be said is, ''There they go again, the Republicans giving a tax cut to the very rich.''

Mr. Chairman, the American Academy of Actuaries said the greatest savings from MSAs will be for the employees who have little or no health expenditures; and the greatest losses will be for those employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women.

The Wall Street Journal article explaining the lack of demand for MSAs stated that consumers using MSAs must generally pay full price for medical services, while managed care plans get discounts of 30 to 60 percent. MSAs discourage preventive care, which leads to more serious health costs. MSAs do not work.

Mr. Chairman, why we should be increasing the ability of very rich people to have a second IRA and deny health care or raise the cost of health care for other workers escapes me. This is an amendment, laughable at best, proposed by people who think that they can buy some more votes by pandering to the very rich by giving away more tax deductions.

□ 1730

I might say that in the previous debate today, people talked about raising the cost of health insurance. There is not one credible, independent study ever conducted that shows the number of uninsured Americans would go up if we passed the Patients' Bill of Rights. I challenge the Republicans to show me such a study.

Mr. SAM JOHNSON of Texas. Mr. Chairman, I yield 1 minute to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Chairman, I rise today in strong support of the amendment offered by my colleagues. There are millions of Americans without health coverage, and they live in every one of our districts. We hear from them every day. One provision that is poised to have a tremendous impact on reducing the number of uninsured is association health plans.

I have heard some of my colleagues contend that AHPs are bad for women. Bad for women? How is affordable health coverage bad for women? Association health plans offer another tool for women to access affordable health insurance. Currently, small business owners, their families and their employees make up over 60 percent of the uninsured. Over half of these people are women. This is a no-brainer. AHPs are

good for women. In fact, AHPs are strongly supported by the National Association of Women Business Owners, Women Impacting Public Policy, in addition to a host of other groups committed to increasing access to health care for hardworking women Americans.

Many small businesses do not have the ability to negotiate affordable health care prices the way big companies can. I think we should give them an opportunity to level this playing field.

I urge all of my colleagues to remember the women and uninsured of America and adopt this amendment.

Mr. STARK. Mr. Chairman, I yield myself such time as I may consume. I ask the gentlewoman from New York if she would care to respond to a question and answer for me if she knows of any women's group in the United States that endorses this outside of perhaps the Eagle Forum.

Mrs. KELLY. If the gentleman will yield, Mr. Chairman, I am sorry, perhaps the gentleman was not listening. Yes. The National Association of Women Business Owners and the Women Impacting Public Policy both. That is only two. There are others.

Mr. STARK. There are?

Mrs. KELLY. Yes.

Mr. STARK. Which others?

Mrs. KELLY. I do not have a list of them in my hand, but there are others.

Mr. STARK. I thank the gentlewoman.

Mr. Chairman, I yield 1½ minutes to the gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Chairman, I rise in strong opposition to this amendment, especially the portion dealing with medical savings accounts. What are those? We all know about retirement savings accounts, IRAs; we know about education savings accounts putting money away for your child's education. Now we have medical savings accounts.

My question to the proponents is, where are individuals going to get all this money to slug into these various accounts? You have got to pay the mortgage, your gas bill, your heat bill and now you are supposed to have all this money left over to give to your IRA, your education IRA and then a medical IRA.

Mr. Chairman, if this passes and becomes law, this is the death knell for employer-sponsored insurance. I say that because only the healthy and the wealthy will be able to put money into medical savings accounts, leaving the rest of us and the sick, to pull the wagon. What will happen is rates will go up, employers will cancel their plan and say, You will have to go into a medical savings account. I can't afford this anymore.

Just to prove my point, the author of the amendment, Mr. THOMAS the chairman of the Committee on Ways and Means, said in March of 1998, that it would be not surprising if a health care package uses the Tax Code to get rid of the employer-sponsored insurance system.''

Mr. Chairman, we see it is right here today and if this passes, say good-bye to your employer-sponsored health insurance because the rates are going to be too high for employers to keep it. Again, this plan is for the healthy and wealthy.

Mr. SAM JOHNSON of Texas. Mr. Chairman, I yield 1 minute to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. I thank the gentleman for yielding time.

Mr. Chairman, it is interesting to follow the previous speaker, because medical savings accounts hold the best promise for allowing Americans to break out of managed care entirely and take control of their own health care for the first time in many years. I do not have time to go into this a lot, but some of the most serious, real problems faced today by medical savings account companies is that a far higher mix of seriously ill patients are flocking into MSAs than other health plans, to the point that negative selection is currently hurting MSAs, not traditional insurance. The reason so many people with preexisting conditions are flocking to MSAs is that MSAs provide freedom, freedom to get the drug your doctor ordered, freedom to see your specialist without seeking permission from anyone or to have to file an appeal for an overturn.

I urge my colleagues to support this amendment for medical savings accounts because I think that it will help all of us do one of the things I have been trying to do all along, is get away from managed care.

Mr. STARK. Mr. Chairman, I am happy to yield 1½ minutes to the distinguished gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Chairman, as the sponsor of the amendment pointed out, this amendment deals with two points: one is medical savings accounts, the other is association health plans. I want to deal with the second issue, because I think it will have the unintended consequence of actually increasing the number of uninsured, not increasing the number of insured.

Let me just give you an example. In my State of Maryland, we have already had small market reform. Small companies can already join a state-regulated plan that is much less expensive than on the open market. If we are to adopt the associated health plan that is in this amendment, it will be the death knell for the small market reform in the State of Maryland.

Maryland is not alone. Other States have done the same thing. The reason quite frankly is the success of the Maryland small market reform is based upon all small employers coming into the Maryland plan, not picking and choosing between different plans. If we allow the associated health plans, that means there will be less companies insured in the State of Maryland. Do not take my word for it; take the word of Steve Larsen, the insurance commissioner for the State of Maryland, who is urging us not to pass this amendment and points out that the National Association of Insurance Commissioners oppose this amendment.

I would urge my colleagues to reject this amendment because it will increase the number of uninsured and reduce the opportunity for small companies in this country.

Mr. SAM JOHNSON of Texas. Mr. Chairman, I yield 1½ minutes to the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Chairman, I thank the gentleman for yielding time. I am curious as I watch this debate over medical savings accounts from the other side, if you are so much against MSAs, then why do you expand MSAs in your own bill? The Ganske-Dingell bill has medical savings accounts expansion and extension of them in their own legislation. So if they are so rotten, why are you advocating them in your own legislation?

Mr. Chairman, what this bill is about is whether or not we are going to improve the quality of health care for all Americans. That is the sole purpose of this bill. What this amendment gives us a chance to do is determine whether or not we can also improve the accessibility and affordability of health care. We all know that health care is getting too expensive, that it is inaccessible for too many people. This bill will do many great things to improve the quality of health care, but we need to work on making it more affordable for working families and we need to make it more accessible.

Association health plans, which is also in this amendment which is being ignored right now, allows the small little guy, the small businesses to band together to jointly purchase health insurance so they can get that big volume discount purchasing power that the big companies have. That is what we are accomplishing in this. We are giving small businesses, where 85 percent of the working family works for, the chance to get the same kind of health insurance deals that large corporations do, making health care more accessible and more affordable. Medical savings accounts as validated in the opposition's bill also expands freedom of choice in health care.

Mr. STARK. Mr. Chairman, I yield 1½ minutes to the gentleman from California (Mr. BECERRA).

Mr. BECERRA. Mr. Chairman, I thank the gentleman for yielding me this time.

My wife always tells me that as she was going through medical school, the axiom that they always were told to remember was ''do no harm.'' If you are going to go out there and be a physician and treat people, remember that if nothing else, you try to do no harm.

I do not understand why, if that is what doctors rely upon as they continue their career and their practice to try to heal and help, why we all of a

sudden have to go against all those good physicians, all those good health care providers who are saying, please, do no harm to the Patients' Bill of Rights that we had, the same bill that last year got some 270 votes from the same Chamber. Why did we have to go into the back room and do this harm through these damaging three amendments that we have here before us? Why is it that we have to strip the accountability from the bill that would make sure that HMOs and insurance plans provide what patients want, the accountability. If you do harm to them, they have the right to go after you to get a remedy. Why is it that we strip away from those patients who are injured or perhaps even killed the ability to go after those who committed malpractice? Why? This is our chance to tell the American public that we believe, just as doctors do, that we should do no harm.

We have a great base bill before us. We should follow what we did last year. We should have the bipartisan vote that gave us 271 people in this same House of Representatives to vote for it and move forward and have what the American people want, a bill that will do no harm. Unfortunately, these amendments are killer, poison amendments. Please vote against all three of these amendments that are coming up and vote for the Dingell bill which is the true Patients' Bill of Rights.

Mr. SAM JOHNSON of Texas. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania (Mr. ENGLISH), a member of the Committee on Ways and Means.

Mr. ENGLISH. Mr. Chairman, in 1996 Congress provided patients with options to save for their health care needs and manage their own health care needs by creating medical savings accounts. But certain limitations placed on those accounts never allowed patients to fully realize the promise of MSAs.

Today, I urge my colleagues to make those accounts permanent and repeal the limitations put on them by supporting this amendment, this pro-consumer amendment. This amendment allows any size company to offer MSAs and also allows individuals to purchase MSAs, giving more people the power to choose the health care professionals, services and products that best meet their needs as individuals. It allows MSAs to be offered under cafeteria plans that will greatly expand the number of consumers that can be reached by MSAs and treat MSAs like other health care plans.

Many insurers have been reluctant to offer medical savings accounts because the cap limits the size of the market in which MSAs can be offered. We would repeal that cap. That is fundamentally pro-consumer legislation.

Mr. STARK. Mr. Chairman, I am happy to yield 2½ minutes to the gentleman from North Dakota (Mr. POMEROY), a former insurance commissioner of that fine State.

Mr. POMEROY. Mr. Chairman, I thank the gentleman for yielding time.

Back home we say you can take a pig, put lipstick on it, smell it and call it Monique, but it is still a pig. AHPs, association health plans, contained in this bill are just another iteration of what has been tried in the past and failed in the past to the disadvantage of small employers and their employees: multiple employer trusts in the early 1980s, giving way to multiple employer welfare arrangements in the late 1980s.

What these were were efforts to have unregulated insurance pools across small employers managed by associations. The net result, no regulation, no adequate oversight in terms of capitalization of these programs; and while the premiums were cheap, when the claims came in, the companies were not there. It is not just a matter of having a policy for purposes of having access to coverage. You want to make sure you actually have a solvent entity to pay the claim when you send in the bill. That is the problem about deregulating these association health plans. We have learned this lesson once. We have learned this lesson twice. Why, oh why, oh why on a bill that we are trying to increase consumer protections would the majority ask us to learn it yet a third time to the disadvantage again of small employers and the people covered in those programs?

There is another adverse feature to association health plans and that is that it busts up the risk pool. The way health insurance works is you get a whole lot of folks, healthy ones, medium healthy ones, sick ones, you put all their risks together and then you have a mechanism that can pay claims on those who incur medical services. This would segment out by attracting disproportionately healthy groups least likely to incur medical services. Everybody else would be in groups that are aging, groups whose health experience was deteriorating, and the premiums would be skyrocketing.

□ 1745

Do not take my word for it, because the Congressional Budget Office has evaluated this, and the Congressional Budget Office said if AHPs were enacted, four in five workers in small firms, 20 million Americans, would actually receive a rate increase. Only 4.6 million would receive a rate decrease. Why would you have rates go up by a feature of four to one in order to advance Association Health Plans?

It is a bad idea. It is not consumer protection, it is consumer harm. Reject that amendment.

Mr. SAM JOHNSON of Texas. Mr. Chairman, our opinion is that those health plans give people insurance, and they do lower the cost.

Mr. Chairman, I yield 30 seconds to the gentlewoman from Connecticut (Mrs. JOHNSON), a member of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I just would like to point out to my colleagues that in this bill there are solvency standards and a number of reforms that were not in there a number of years ago. What is exciting about the Association Health Plan option is it provides to small businesses the opportunity to offer health plans out from under State mandates, which is exactly what the larger employers have done. My constituents tell me that if they could organize their small business plans under the ERISA law, they could lower premiums 10 percent.

Mr. STARK. Mr. Chairman, I yield myself the balance of my time.

The CHAIRMAN. The gentleman from California is recognized for 30 seconds.

Mr. STARK. Mr. Chairman, the gentleman from North Dakota (Mr. POMEROY) asked, ''Why would anybody do this?'' I would answer that the one need just to look at Golden Rule Financial's contributions to find the answer: soft money, 1997 to 1998, $314,000 to the Republicans, and not a penny to the Democrats. Under this amendment, Golden Rule Insurance Company, the main company that benefits from MSAs, will get $5 billion over the next 10 years.

You guys are selling out too cheap to these lobbyists. You have taken their $300,000 and given them a bill worth 5 billion. That is what the Republicans are doing in this bill. They have sold out to the special interests; they have sold out to the insurance companies. Shame on you.

Mr. SAM JOHNSON of Texas. Shame on the trial lawyers who are trying to win millions of dollars on your bill.

Mr. Chairman, I yield 1 minute to the gentleman from South Dakota (Mr. THUNE).

Mr. THUNE. Mr. Chairman, I thank the gentleman for yielding me time.

Let me say, Mr. Chairman, that we need strong patient protection legislation. We have before us a bill that will do that, will provide access to emergency room, access to clinical trials, direct access for women to OB–Gyn and access to the courts for wrongful treatment.

But this amendment does something more. This amendment improves this legislation by expanding access to health care. There are 86,000 people in my State of South Dakota who do not have health care. Medical savings accounts and association health plans are a means by which our small businesses can make health care more affordable and more accessible to more people.

This is a good amendment, Mr. Chairman. We need to act on this amendment, act on this legislation, provide strong patient protection for people in this country, but also do something to address those who are uninsured, the many people across this country and those in my State of South Dakota who do not have access to health care today.

Let us enact the Thomas-Lipinski-Fletcher amendment and give more

people more access to health care that is affordable by increasing and expanding MSAs and association health plans.

Mr. ANDREWS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this amendment is very much in keeping in theme with the message today from the majority, which is illusions. The Norwood amendment creates the illusion of holding HMOs accountable for their misconduct, and we will discuss that in greater detail in the next amendment. This amendment creates the illusion of covering more of the uninsured Americans with health insurance. It is a remarkable miss of the target that we should be aiming at.

We hear a lot about the 43 million uninsured Americans. It is curious, first of all, that we never hear much from the majority party about the 43 million uninsured Americans in April when we are doing the budget resolution. It only seems to come up when the patients' bill of rights comes up and they need a justification for their position.

First of all, AHPs. The theory behind AHPs is that employers are going to enjoy a reduction in their premiums; and, therefore, more employers are going to buy health insurance and more individuals are going to be covered. That just does not square with the objective analyses that have been done of the AHP concept. One of them was done by the Congressional Budget Office, whose researchers concluded that AHPs would not reduce overall health insurance costs. The CBO found that four in five workers would see their health insurance costs increase under this amendment, under AHP legislation, because of disruption in health insurance markets. So the illusion that premiums would go down is not the fact.

The second problem with AHPs is that it really is a race for the bottom. It preempts and therefore repeals the consumer protection legislation adopted by States all across the country, legislation that requires a minimum length of stay after a C-section for a woman who has given birth, legislation that requires a minimum length of stay after a radical mastectomy. All of these consumer protections are repealed when the AHPs go in.

Maybe there is some argument that prices would go down, that if you eliminate quality standards and fiduciary standard, you could make it very cheap, but it would not be worth the money that people pay. So the argument that more people are going to be insured by AHPs just does not square with the facts. It does not square with the study by Rand researchers Steve Long and Susan Marque, who found that existing AHPs have not reduced insurance costs for participants.

The next idea that is going to get more people insured is individual health savings accounts. This is remarkable. The theory behind this is that a person making $21,000 or $22,000 a year who works full-time and has no health insurance is going to put all of this extra income that she has into one of these medical savings accounts at the end of the week, and that all of this extra income that she generates is going to pile up and provide her with the health benefit that her employer is either unable or unwilling to afford.

I would be curious as to how anyone in the majority could explain to us where this additional income is going to come from? I would invite the majority, I would yield to anyone over there, to tell me what present data tells us about who is participating in MSAs now, what the medium income of the participant is, how many people are participating in MSAs, whether they are in the bottom 30 percent of the wage earners in the country, since most of the uninsured working people in this country are in the bottom 30 percent of wage earners.

So this is a remarkable idea. We are giving low-income, full-time working people the right to put away money that they do not have. We perhaps should also introduce an amendment giving them the right to purchase a Rolls Royce, or a condominium at an expensive resort. It is about as useful to them, because they do not have the money to put away.

Mr. FLETCHER. Mr. Chairman, will the gentleman yield?

Mr. ANDREWS. I yield to the gentleman from Kentucky.

Mr. FLETCHER. Mr. Chairman, would the gentleman please explain to me why MSA expansion is in your bill, and why the patient protections in that bill will not protect those patients in MSAs?

Mr. ANDREWS. Mr. Chairman, reclaiming my time, because it was necessary to build a majority coalition to pass the bill, which we would have done had the leadership brought it to the floor when it was originally promised.

Mr. Chairman, the problem with this amendment is it suffers the illusion, the continuing illusion, that we are going to cover more people. You want to cover more people? Put more money in the S-chip program. Repeal just a little piece of the tax cut that passed a couple of months ago and put more money into the program that has enrolled millions of children, and could enroll their parents, if we extended that. That is the way to enroll more people in health insurance.

You want to enroll more people in health insurance? Let seniors 55 and over buy into Medicare at their own expense. You want to cover more people by health insurance? Expand Medicaid reimbursement to the States. That is the way to do it; not this fraud, not this illusion that is before us today.

Mr. Chairman, I reserve the balance of my time.

Mr. SAM JOHNSON of Texas. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, MSAs are important for more than half of the 43 million small business owners, their employees and their families, and in spite of what you say, the truth is that working-class people do use MSAs, and I am going to quote you.

''All three of us are working middle-class mothers, two of us are single moms, and we all have medical savings accounts that provide health insurance for our families. Our message to people in Washington is plain, unmistakable English that MSAs work.''

Mr. ANDREWS. Mr. Chairman, will the gentleman yield?

Mr. SAM JOHNSON of Texas. I yield to the gentleman from New Jersey.

Mr. ANDREWS. Mr. Chairman, I wonder if the gentleman could tell us the source of the quote he just read?

Mr. SAM JOHNSON of Texas. Mr. Chairman, reclaiming my time, I will get it to the gentleman. I will tell him what he tells me: I will send it to you in writing.

Mr. Chairman, let me say that it is unfortunate that the base bill we are considering does just the opposite of providing insurance for our people. We believe that creating association health plans and expanding medical savings accounts guarantees the access they need. Working together, it helps employees and employers lower the cost of health insurance and gets the benefits they may not have had.

Increasing access to Medical Savings Accounts would help those people struggling to make ends meet. Medical savings accounts empower people to save their own money, tax free, for medical expenses in conjunction with a high deductible health plan. Health expenses can break the family budget. MSAs help cushion the blow. They help people get the care they need from a doctor of their choice or a hospital of their choice. The base bill does not do that.

It is time to focus on the uninsured, focus on access and affordability. This amendment is good for America and the 43 million Americans who do not have health insurance.

Do what is right. Vote for this amendment.

Mr. Chairman, I yield the rest of my time to the gentleman from Kentucky (Mr. FLETCHER) and ask unanimous consent that he be allowed to control the time.

The CHAIRMAN. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. ANDREWS. Mr. Chairman, I am pleased to yield 2 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, it is ironic that the gentleman from California (Chairman THOMAS) calls this amendment the access amendment. It is also disingenuous.

This amendment would reduce access to health insurance, not increase it. The gentleman from California (Chairman THOMAS) knows that. He knows

this amendment has nothing to do with access; it has everything to do with helping a few individuals in a few businesses at the expense of the rest of us. It has everything to do with campaign contributions, as the gentleman from California (Mr. STARK) pointed out earlier.

Association health plans and MSAs make health insurance less expensive for a few healthy individuals and a few employers, while costs rise for every other individual and every other employer. Association health plans skim low-risk businesses from the rest of the insurance pool. Every other bill carries a larger burden when more risk is spread over fewer groups.

Medical savings accounts, they can be a great deal when you are 100 percent healthy. When you are sick, they turn into an expensive disappointment. The Congressional Research Service estimates that commercial insurance premiums will increase 2 percent or more if association plans are permitted.

Iris Lav and Emmett Keeler, two highly respected health services researchers, say that premiums for conventional insurance could more than double if MSA use becomes widespread.

Last night at midnight, the gentleman from California (Chairman THOMAS) sold this House a bill of goods, $27 billion in tax giveaways to the Nation's oil companies. I ask my colleagues, do not buy it again. A real patients' bill of rights is not going to blow the top off insurance premiums, but association health plans and medical savings accounts, sweetheart deals for the fortunate few, certainly will.

I urge Members to vote against the ill-conceived Thomas amendment.

Mr. FLETCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Ohio (Mr. BOEHNER), Chairman of the Committee on Education and the Workforce.

Mr. BOEHNER. Mr. Chairman, let me once again congratulate my colleague, the gentleman from Kentucky (Mr. FLETCHER), for his tremendous job in helping to move this entire process along this year. He has spent weeks and months, I might add, trying to build consensus for how do we break the gridlock and how do we move a real patients' bill of rights.

Now, my colleague, who was just here opposing association health plans and medical savings accounts, it should not surprise any of us, because he is one of the larger promoters of a single payer national health care system. My goodness, if we get people insured by private insurance, which is what most people want, there will not be any need for a single payer system.

□ 1800

In 1992, when this issue of health care began to be a big issue in America, we were worried about those 36 million Americans who had no health insurance. We remember the 1992 presidential campaign. We remember 1993, when we had this big effort of having a national health insurance plan, a card for every American. Then Americans stood up and said no, no, please, we do not want that. Our own health insurance is very good.

Then, over the last 6 years, all we have done is talk about patients' rights, and while they are important and we need to deal with them, let us admit that the far bigger problem in America today are the 43 million Americans who have no health insurance at all. All these patient protections, all the consumer protections my colleague just talked about mean absolutely nothing to those Americans who have no health insurance.

What we want to do under this amendment is make it easier for small businesses to offer health insurance for their employees, because 80 percent of those 43 million Americans have jobs, they have full-time jobs, and they work for smaller employers who do not have the ability to create large pools. But by allowing them to work in an association, whether it be the NFIB, whether it be the Association of American Florists, and create larger pools, they will get lower rates, they will have a better opportunity at getting health insurance. And why should we not help them?

Mr. FLETCHER. Mr. Chairman, I yield 1 minute to the gentleman from California (Mr. DOOLEY), who has cosponsored the Small Business Fairness Act, which is the bill on association health plans.

Mr. DOOLEY of California. Mr. Chairman, I rise in support of the association health plan proposal before us.

The number one problem in health care facing Americans is not their problems with their managed care organization; the number one problem facing Americans today is the fact that we have 43 million of our citizens who are uninsured.

I represent a district in the Central Valley of California, one of the lowest income areas, one that has a lot of families that are farm workers. It is predominantly Latino in its makeup. Association health plans hold the promise of allowing associations to come together to offer these families and the children of these farm worker families a health insurance policy that otherwise would not be available to them.

Mr. Chairman, we have to come to understand that what we are trying to do here is to provide a mechanism for farmers and small business people to come together, to come together so that they can offer a plan that is similar to what Boeing, Microsoft and GM are offering to their employees. This holds the promise of ensuring that some of those 43 million people, some of whom are living in my district, some of whom have the lowest incomes, will have access to a quality health insurance plan that otherwise they would be denied.

Mr. FLETCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. ARMEY), our majority leader.

Mr. ARMEY. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I would like to thank the gentleman from Kentucky (Mr. FLETCHER) for offering this amendment. I would also like to thank the gentleman from Illinois (Mr. HASTERT), the Speaker of the House; the gentleman from California (Mr. THOMAS); the gentleman from Illinois (Mr. LIPINSKI); the gentlewoman from Connecticut (Mrs. JOHNSON); and the gentleman from Georgia (Mr. NORWOOD) for their leadership and their continuing strong commitments to the Archer Medical Savings Accounts.

Mr. Chairman, patients need more than a bill of rights, they need a declaration of independence. Millions of American families today find themselves trapped in HMOs that they did not choose and they do not like. This amendment offers them a get-out-of-jail-free card. It offers them hope, gives them options that help them find peace of mind and more control over their health care treatments. It begins to address the basic unfairness in the Tax Code that created the HMO trap in the first place.

There are too many people in this debate, Mr. Chairman, I believe, who have nothing to say except patients should have a right to sue their HMO. But I submit that, before that, they should have a right to fire their HMO.

Mr. Chairman, this is America. We should have the freedom to take our business wherever we choose. Unfortunately, today's Tax Code denies that freedom to millions of American families, especially the poor and minorities and especially Hispanics.

If we really care about the uninsured, if we really care about the waitresses, the house painters, the field workers and the others shut out of affordable health care today, then we must make the taxation of health benefits fair for everyone, regardless of where they work or how much they make. By making Archer Medical Savings Accounts available to everyone, this amendment starts us down the road towards basic tax fairness.

Medical savings accounts can be a godsend for the uninsured. According to the IRS, one-third of the MSAs sold under the current pilot project have been purchased by folks who have otherwise been uninsured for at least the previous 6 months. Imagine how many uninsured people we could help if MSAs were given a fair shot in the marketplace, as this amendment would do.

Mr. Chairman, this is an amendment with a heart. It would be heartless to defeat it.

Mr. ANDREWS. Mr. Chairman, I yield myself such time as I may consume.

Under the budget rules of the House of Representatives, when someone brings a bill to the floor that would reduce revenue flow of the Treasury, they

they normally have to show where it is going to be paid for. This amendment was given an exception to that, so it is not subject to a point of order.

I wonder if anyone on the majority side could tell us where the $5 billion over the next 10 years is going to come from to pay for this bill.

Mr. Chairman, I yield to anyone on the majority side to tell us where the $5 billion is going to come from.

Mr. THOMAS. Mr. Chairman, I thank the gentleman for yielding.

I would tell the gentleman we have a golden opportunity today to find more than $2 billion of the amount that the gentleman indicated, because as the gentleman well notes, the medical malpractice amendment that will be up after we pass the Norwood amendment is scored by the appropriate scoring agencies as saving almost $2 billion.

Mr. ANDREWS. Mr. Chairman, reclaiming my time, I wonder where the other $3 billion might come from, the other $3 billion.

Mr. THOMAS. Mr. Chairman, will the gentleman yield?

Mr. ANDREWS. I yield to the gentleman from California.

Mr. THOMAS. Mr. Chairman, we have a number of other measures that we will move along. As chairman of the Committee on Ways and Means, I can assure the gentleman that $3 billion over 10 years is not that large an amount of money to find, and as chairman of the Committee on Ways and Means, I pledge to the gentleman, we will find it.

If that is the gentleman's concern about not supporting the amendment, I hope he now supports it.

Mr. ANDREWS. Mr. Chairman, will the gentleman from California (Mr. THOMAS) do it by raising other revenues by $3 billion, by raising taxes?

Mr. THOMAS. Mr. Chairman, if the gentleman would again yield, I would tell the gentleman there is no need for $3 billion to raise taxes. There are a number of administrative changes, cleaning up provisions that are already in the law that the gentleman was instrumental in putting on the books, where we can find savings of far more than that.

Mr. ANDREWS. Mr. Chairman, reclaiming my time, I look forward to that.

Mr. Chairman, I reserve the balance of my time.

Mr. FLETCHER. Mr. Chairman, I yield 30 seconds to the gentleman from Georgia (Mr. ISAKSON).

Mr. ISAKSON. Mr. Chairman, I rise on behalf of those 43 million people who are America's salesmen, America's independent contractors, America's retail clerks, America's small businessmen and women, and I would ask each of those who oppose this to ask yourself this question before they vote: Why should we deny 43 million Americans the patients' rights, that those we are fighting for already enjoy, by not giving them better access to health care coverage which would otherwise not be available?

Mr. FLETCHER. Mr. Chairman, I yield 1 minute to the gentleman from Illinois (Mr. PHELPS).

Mr. PHELPS. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I rise today in support of this important amendment, which I have cosponsored. While we are discussing the Patients' Bill of Rights, it is important to remember that one of the major problems facing our great Nation today is the problem of the uninsured.

As a member of the Committee on Small Business, I know the positive effect that association health plans and medical savings plans can have on employees and employers of small businesses across the Nation. Of the 43 million uninsured in America, 60 percent of those either own or work in small business.

Small business employers need the opportunity to offer their employees a strong benefits package at a reasonably low cost. AHPs allow small businesses to join together across State lines to obtain the accessibility, affordability and choice in the health care marketplace now available to employees in large companies and organized labor unions.

Medical savings accounts are extremely beneficial because they actually allow individuals to be in control of their own health care, allowing them to decide how they want their money to be spent. More than one-third of the people who currently participate in MSAs were previously uninsured. It only makes sense to provide greater access to the uninsured, and AHPs and MSAs help do this.

Mr. FLETCHER. Mr. Chairman, I yield 30 seconds to the gentleman from Illinois (Mr. MANZULLO), chairman of the Committee on Small Business.

(Mr. MANZULLO asked and was given permission to revise and extend remarks.)

Mr. MANZULLO. Mr. Chairman, as chairman of the Committee on Small Business, I receive thousands of letters from small employers, many from northern Illinois, who are struggling with surging health care costs for their employees. We call this ''Health Care Horror Stories from America's Small Employers.''

Today, we have an opportunity to protect patients' rights and improve the quality of health care. This amendment allows small employers the ability to bring down health insurance costs for themselves and their employees by joining association health plans, similar to the way that labor unions pool their members to lower premiums for their insurance. We cannot possibly believe we are protecting patients if more small entrepreneurs stop paying for coverage.

Mr. Chairman, I encourage the adoption of this amendment.

As Chairman of the Committee on Small Business, I am troubled by the fact that of the 43 million Americans with no health insurance, more than 60 percent are the families of small entrepreneurs and their employees.

I have received thousands of letters from small employers—many from the northern Illinois district I represent—who are struggling with surging health care costs for their employees.

Geoff Brook is one of my constituents who offers health care coverage to his employees at Energy Dynamics, Inc. in Machesney Park, Illinois. The last three years especially, premiums have skyrocketed and Geoff has reluctantly been forced to cancel coverage for the families of his employees and raise deductibles for his employees themselves. He recently received a notice from his insurance company that his employees' premiums were going to increase another 34 percent for the coming year. ''As the owner of a 20-year-old small business with 18 employees, I can tell you that employee health insurance is already at the point where any further rate increases will cause us to discontinue coverage for our employees,'' Geoff said.

Mark O'Donnell is another of my constituents who employs 35 people at Kenwood Electrical Systems, Inc. in Rockford, Illinois. Mark writes, ''Our health insurance costs were raised 43 percent last year and 34 percent this year and there is nothing we can do about it. We have a real problem here.''

And Linda Taylor, who owns Taylor Auto Parts with her husband, Larry, in Woodstock, Illinois, writes, ''Health care costs and insurance are draining us. Last year, we had a 14 percent increase and had to change to $1,000 deductibles. Now, the costs are going up 21 percent again. I truthfully do not know how to handle this latest increase,'' said Linda, who provides health care coverage to four employees.

This is not a unique problem in my district. Access to healthcare is a problem our small entrepreneurs face each year they have decide between paying escalating premiums and dropping coverage of their employees. Large health plans may spread the increased costs over their large applicant pools without much of a change in enrollment. A large business or union health plan enrollee might spend slightly more on healthcare, but it will probably not push them out of the health care system.

The small entrepreneur and his or her employees, however, struggle with radical increases in health care premiums. Especially for a business with fewer than 50 employees, its health care premiums skyrocket when a member of the small enrollee pool becomes ill or injured. When the husband of a Chrysler employee goes to an emergency room, the Chrysler health insurance plan easily spreads out the cost, but for a small auto mechanic, the cost of his employee's trip to the emergency room forces a small group of workers to shoulder a significant burden.

Fortunately, today, we have an opportunity to protect patients' rights and improve the quality of health care without causing more Americans to lose their health insurance. This imperative amendment will give small employers hope to bring down health insurance costs for themselves and their employees by joining Association Health Plans and through expanded use of Medical Savings Accounts.

Association Health Plans (AHPs) will provide greater choice and access to affordable, high quality, private sector health insurance for millions of working families employed in small businesses.

AHPs empower small business owners, who currently cannot afford to offer health insurance to their employees, to access health insurance through trade and professional associations and Chambers of Commerce. In other words, AHPs allow national trade and professional associations, like the National Federation of Independent Business, the National Restaurant Association or the U.S. Chamber of Commerce, to sponsor health care plans. The small business owners who are members of the associations can buy into these plans for themselves and their employees.

These associations would cover very large groups, would enjoy large economies of scale to that of a large business or union, and could offer self-funded plans that would not have to provide any margin for insurance company profits.

AHPs give small businesses and the self-employed the freedom to design more affordable benefit options and offer their workers access to health care coverage. These new coverage options promote greater competition, lower costs and new choices in health insurance markets. By allowing individuals and small employers to join together, AHPs promote the same economies of scale and purchasing clout that workers in large companies currently realize.

Expansion of Medical Savings Accounts (MSAs) will make insurance more affordable for businesses with qualifying high deductible plans. Expansion of MSAs will encourage more individuals to place tax-deductible funds into savings accounts for use in routine medical care while still allowing a wide choice among doctors.

Initially created by Health Insurance Portability and Accountability Act of 1996, MSAs have not been fully utilized by their target sector. However, enacting simple reforms and expansions will allow more small businesses to cut down on their healthcare costs. These provisions include repealing limits on the number of MSAs, making active accounts generally available to anyone with qualifying high deductible insurance, allowing contributions up to the amount of the insurance deductible, allowing contributions to be made both by employers and account owners, lowering minimum insurance deductibles for single and family coverage, allowing use under cafeteria plans, and allowing plans not to have a deductible for preventive care, even if this is not required by state law.

AHP and MSA legislation will not directly offset the increased costs of healthcare when a Patients' Bill of Rights is enacted. However, small businesses are the sector most likely to cease offering insurance because of increase costs, and AHP and MSA legislation will allow these groups to access and afford quality healthcare.

We cannot possibly believe we are protecting patients if more small entrepreneurs stop paying for coverage—which will happen with rising premiums. Association Health Plan and Medical Savings Account provisions are the only responsible way to protect patients.

Mr. ANDREWS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the record shows that this amendment will not substantially increase coverage. The association health plans will not substantially reduce premiums; therefore, more employers will not be enticed to buy in. MSAs are not going to work for low- and modest-income people who do not have money to put into the MSAs.

This is an illusion, much like the Norwood amendment that we are going to debate next. I urge the defeat of the amendment.

Mr. Chairman, I yield back the balance of my time.

Mr. FLETCHER. Mr. Chairman, I yield 1 minute to the gentleman from California (Mr. CUNNINGHAM).

Mr. CUNNINGHAM. Mr. Chairman, the gentleman on the other side cannot hide the truth. Associated health care plans, if you have a union or large business that has maybe 3,000 or 4,000 employees, they can go to a health care organization and negotiate lower rates because it spreads out the risk.

We are asking that maybe all the bakers get together, all the barbers get together, little groups that can form into larger groups so that they can negotiate those health care plans with lower rates. If we have lower rates, we are going to have more people access into them, so the gentleman is just flat wrong.

Another gentleman talked about taxes. The gentleman from Missouri (Mr. GEPHARDT) just last week said he wants to raise taxes. In 1993, he was proud of it. They raised taxes on the middle class. We want to give it back to the American people for medical savings accounts, not have campaign finance fund-raisers with Jane Fonda.

Mr. FLETCHER. Mr. Chairman, I yield 30 seconds to the gentleman from Indiana (Mr. PENCE).

(Mr. PENCE asked and was given permission to revise and extend his remarks.)

Mr. PENCE. Mr. Chairman, I rise in strong support of the amendment and of Indiana's small business owners. For too long they have lacked access to affordable health care options to offer their employees.

The answer, Mr. Chairman, is fairness. Large corporations and labor unions can offer health insurance across State lines under a single uniform code and reap all of the benefits of the economies of scale. Congress today in this amendment must level the playing field for small business.

Let us grant small businesses the same rights as Fortune 500 companies. Association health plans are the answer, and I urge my colleagues to support this amendment.

Mr. FLETCHER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, as we look at the problem facing America and health care, the most daunting problem we have are the 43 million that are uninsured. The majority of those uninsured are working individuals. The majority of those working individuals are in small businesses. What we do with association health plans is allow those small businesses to come together, to insure themselves across the Nation.

Mr. Chairman, this last year when I was going across my district, I talked to farmers that were paying on the individual market for their family up to $800 and 900 a month. That was unaffordable for them. Now, imagine if the American Farm Bureau could provide a plan and pool across the Nation and offer that individual farmer a policy for his family that was 30 percent, maybe more than that, reduced from what he is paying now; what impact would that have on the farmers across this country?

□ 1815

Or the other 81 or number of organizations, associations that we have supporting this bill, because their associations should be able to offer their members a plan just like unions do, multi-employer plans now.

So I think in addition to that, when we combine this to the Ganske-Dingell bill and hopefully the Norwood amendment, we provide all the patient protections that ensure that patients get not only this pooled health care plan that will reduce costs, but we provide them the patient protections that everyone will get across this Nation including the accountability.

I want to encourage my colleagues to vote for this measure to improve the health care in America and provide more insurance for Americans.

Mrs. MORELLA. Mr. Chairman, while I want to increase health insurance access for all Americans, Association Health Plans (AHPs) are not the way to do it.

The provisions put forth in this amendment would exempt AHPs from State laws requiring the coverage of services for women, children, and other vulnerable groups. In my State of Maryland, AHPs would be exempt from requirements for insurance plans to cover maternity care, pediatric services for children, mammography and cervical cancer screening, contraceptives, nurse midwives, mastectomy stays and breast reconstruction.

Exempting AHPs from State insurance reform laws is also bad public policy. The National Governors Associations, National Conference of State Legislatures, and the National Association of Insurance Commissioners have written in staunch opposition to these ''access'' provisions.

Moreover, this proposal will harm many workers, while doing little to address the amount of uninsured individuals. The Congressional Budget Office (CBO) projected that 20 million people would experience a premium rate increase under this proposal, while only 5 million would see their rates decline. The CBO also found that any premium reductions by AHPs would stem from attracting healthier members from State insurance pools, which by the way, Medical Savings Accounts also end up doing, and eliminate State required health care benefits.

In 1974, Congress passed a law creating an exemption for AHPs. It was an unmitigated disaster. A report by the former chief counsel of the Senate Permanent Subcommittee on Investigations has noted that the current AHP exemption repeats the historical mistakes of the original 1974 exemption. Congress had to pass a law several years later returning regulatory authority to the States. Let's not make the same mistake twice.

The CHAIRMAN. All time for debate on this amendment has expired.

The question is on the amendment offered by the gentleman from California (Mr. THOMAS).

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. ANDREWS. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 236, noes 194, not voting 4, as follows:

[Roll No. 328]

YEAS—236

Aderholt	Goss	Osborne
Akin	Graham	Ose
Armey	Granger	Otter
Bachus	Graves	Oxley
Baker	Green (WI)	Paul
Ballenger	Greenwood	Pence
Barcia	Grucci	Peterson (MN)
Barr	Gutknecht	Peterson (PA)
Bartlett	Hall (TX)	Petri
Barton	Hansen	Phelps
Bass	Harman	Pickering
Bereuter	Hart	Pitts
Biggert	Hastert	Platts
Bilirakis	Hastings (WA)	Pombo
Blunt	Hayes	Portman
Boehlert	Hayworth	Pryce (OH)
Boehner	Hefley	Putnam
Bonilla	Herger	Quinn
Bono	Hilleary	Radanovich
Brady (TX)	Hobson	Ramstad
Brown (SC)	Hoekstra	Regula
Bryant	Horn	Rehberg
Burr	Hostettler	Reynolds
Burton	Houghton	Riley
Buyer	Hulshof	Rogers (KY)
Callahan	Hunter	Rogers (MI)
Calvert	Hutchinson	Rohrabacher
Camp	Hyde	Ros-Lehtinen
Cannon	Isakson	Roukema
Cantor	Istook	Royce
Capito	Jenkins	Ryan (WI)
Castle	Johnson (CT)	Ryun (KS)
Chabot	Johnson (IL)	Saxton
Chambliss	Johnson, Sam	Scarborough
Coble	Jones (NC)	Schaffer
Collins	Keller	Schrock
Combest	Kelly	Sensenbrenner
Condit	Kennedy (MN)	Sessions
Cooksey	Kerns	Shadegg
Cox	King (NY)	Shaw
Cramer	Kingston	Shays
Crane	Kirk	Sherwood
Crenshaw	Knollenberg	Shimkus
Cubin	Kolbe	Shuster
Culberson	LaHood	Simmons
Cunningham	Largent	Simpson
Davis, Jo Ann	Larsen (WA)	Skeen
Davis, Tom	Larson (CT)	Smith (MI)
Deal	Latham	Smith (NJ)
DeLay	LaTourette	Smith (TX)
DeMint	Leach	Smith (WA)
Diaz-Balart	Lewis (CA)	Souder
Dooley	Lewis (KY)	Stearns
Doolittle	Linder	Stump
Dreier	LoBiondo	Sununu
Duncan	Lucas (KY)	Sweeney
Dunn	Lucas (OK)	Tancredo
Ehlers	Maloney (CT)	Tauzin
Emerson	Manzullo	Taylor (NC)
English	Mascara	Terry
Everett	McCrery	Thomas
Ferguson	McHugh	Thompson (CA)
Flake	McInnis	Thornberry
Fletcher	McKeon	Thune
Foley	Mica	Tiahrt
Forbes	Miller (FL)	Tiberi
Fossella	Miller, Gary	Toomey
Frelinghuysen	Moran (KS)	Traficant
Gallegly	Moran (VA)	Upton
Gekas	Murtha	Vitter
Gibbons	Myrick	Walden
Gilchrest	Nethercutt	Walsh
Gillmor	Ney	Wamp
Gilman	Northup	Watkins (OK)
Goode	Norwood	Watts (OK)
Goodlatte	Nussle	Weldon (FL)
Weldon (PA)	Wicker	Young (AK)
Weller	Wilson	Young (FL)
Whitfield	Wolf	

NAYS—194

Abercrombie	Green (TX)	Neal
Ackerman	Gutierrez	Oberstar
Allen	Hall (OH)	Obey
Andrews	Hastings (FL)	Olver
Baca	Hill	Ortiz
Baird	Hilliard	Owens
Baldacci	Hinchey	Pallone
Baldwin	Hinojosa	Pascrell
Barrett	Hoeffel	Pastor
Becerra	Holden	Payne
Bentsen	Holt	Pelosi
Berkley	Honda	Pomeroy
Berman	Hooley	Price (NC)
Berry	Hoyer	Rahall
Bishop	Inslee	Rangel
Blagojevich	Israel	Reyes
Blumenauer	Jackson (IL)	Rivers
Bonior	Jackson-Lee (TX)	Rodriguez
Borski	Jefferson	Roemer
Boswell	John	Ross
Boucher	Johnson, E. B.	Rothman
Boyd	Jones (OH)	Roybal-Allard
Brady (PA)	Kanjorski	Rush
Brown (FL)	Kaptur	Sabo
Brown (OH)	Kennedy (RI)	Sanchez
Capps	Kildee	Sanders
Capuano	Kilpatrick	Sandlin
Cardin	Kind (WI)	Sawyer
Carson (IN)	Kleczka	Schakowsky
Carson (OK)	Kucinich	Schiff
Clay	LaFalce	Scott
Clayton	Lampson	Serrano
Clement	Langevin	Sherman
Clyburn	Lantos	Shows
Conyers	Lee	Skelton
Costello	Levin	Slaughter
Coyne	Lewis (GA)	Snyder
Crowley	Lofgren	Solis
Cummings	Lowey	Spratt
Davis (CA)	Luther	Stark
Davis (FL)	Maloney (NY)	Stenholm
Davis (IL)	Markey	Strickland
DeFazio	Matheson	Stupak
DeGette	Matsui	Tanner
Delahunt	McCarthy (MO)	Tauscher
DeLauro	McCarthy (NY)	Taylor (MS)
Deutsch	McCollum	Thompson (MS)
Dicks	McDermott	Thurman
Dingell	McGovern	Tierney
Doggett	McIntyre	Towns
Doyle	McKinney	Turner
Edwards	McNulty	Udall (CO)
Ehrlich	Meehan	Udall (NM)
Engel	Meek (FL)	Velazquez
Eshoo	Meeks (NY)	Visclosky
Etheridge	Menendez	Waters
Evans	Millender-McDonald	Watson (CA)
Farr	Miller, George	Watt (NC)
Fattah	Mink	Waxman
Filner	Mollohan	Weiner
Ford	Moore	Wexler
Frank	Morella	Woolsey
Frost	Nadler	Wu
Gephardt	Napolitano	Wynn
Gonzalez		
Gordon		

NOT VOTING—4

Ganske	Lipinski
Issa	Spence

□ 1840

Messrs. BERMAN, INSLEE, BAIRD, and SHOWS changed their vote from ''aye'' to ''no.''

Mrs. ROUKEMA and Ms. HARMAN changed their vote from ''no'' to ''aye.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

Mr. ISSA. Mr. Chairman, on rollcall No. 328, I was inadvertently detained. Had I been present, I would have voted ''aye''.

The CHAIRMAN. It is now in order to consider amendment No. 2 printed in House Report 107–184.

AMENDMENT NO. 2 OFFERED BY MR. NORWOOD

Mr. NORWOOD. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 offered by Mr. NORWOOD:

Amend section 402 to read as follows:

SEC. 402. AVAILABILITY OF CIVIL REMEDIES.

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

''(n) CAUSE OF ACTION RELATING TO CLAIMS FOR HEALTH BENEFITS.—

''(1) CAUSE OF ACTION.—

''(A) IN GENERAL.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decisionmaker described in paragraph (2) fails to exercise ordinary care—

''(I) in making a determination denying the claim for benefits under section 503A (relating to an initial claim for benefits),

''(II) in making a determination denying the claim for benefits under section 503B (relating to an internal appeal), or

''(III) in failing to authorize coverage in compliance with the written determination of an independent medical reviewer under section 503C(d)(3)(F) that reverses a determination denying the claim for benefits, and

''(ii) the delay in receiving, or failure to receive, benefits attributable to the failure described in clause (i) is the proximate cause of personal injury to, or death of, the participant or beneficiary,

such designated decisionmaker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

''(B) REBUTTABLE PRESUMPTION.—In the case of a cause of action under subparagraph (A)(i)(I) or (A)(i)(II), if an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) upholds the determination denying the claim for benefits involved, there shall be a presumption (rebuttable by clear and convincing evidence) that the designated decisionmaker exercised ordinary care in making such determination.

''(2) DESIGNATED DECISIONMAKER.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The plan sponsor or named fiduciary of a group health plan shall, in accordance with this paragraph with respect to a participant or beneficiary, designate a person that meets the requirements of subparagraph (B) to serve as a designated decisionmaker with respect to the cause of action described in paragraph (1), except that—

''(I) with respect to health insurance coverage offered in connection with a group health plan, the health insurance issuer shall be the designated decisionmaker unless the plan sponsor and the issuer specifically agree in writing (on a form to be prescribed by the Secretary) to substitute another person as the designated decisionmaker; or

''(II) with respect to the designation of a person other than a plan sponsor or health insurance issuer, such person shall satisfy the requirements of subparagraph (D).

''(ii) PLAN DOCUMENTS.—The designated decisionmaker shall be specifically designated as such in the written instruments of the plan (under section 402(a)) and be identified as required under section 121(b)(15) of the Bipartisan Patient Protection Act.

''(B) REQUIREMENTS.—For purposes of this paragraph, a designated decisionmaker meets the requirements of this subparagraph

with respect to any participant or beneficiary if—

''(i) such designation is in such form as may be specified in regulations prescribed by the Secretary,

''(ii) the designated decisionmaker—

''(I) meets the requirements of subparagraph (C),

''(II) assumes unconditionally all liability arising under this subsection in connection with actions and failures to act described in subparagraph (A) (whether undertaken by the designated decisionmaker or the employer, plan, plan sponsor, or employee or agent thereof) during the period in which the designation under this paragraph is in effect relating to such participant or beneficiary, and

''(III) where subparagraph (C)(ii) applies, assumes unconditionally the exclusive authority under the group health plan to make determinations on claims for benefits (irrespective of whether they constitute medically reviewable determinations) under the plan with respect to such participant or beneficiary, and

''(iii) 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)(15) of the Bipartisan Patient Protection Act.

Any liability assumed by a designated decisionmaker pursuant to this paragraph shall be in addition to any liability that it may otherwise have under applicable law.

''(C) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity is qualified under this subparagraph 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 subparagraph (A) 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 certification of such ability. Such certification shall be provided to the plan sponsor or named fiduciary upon designation under this paragraph and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

''(ii) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a health insurance issuer, such issuer is the only entity that may be qualified under this subparagraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

''(D) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of subparagraphs (A)(i)(II) and (C)(i), the requirements relating to the financial obligation of an entity for liability shall include—

''(i) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this subsection; or

''(ii) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this subsection.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of clauses (i) and (ii) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this subparagraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

''(E) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care or treatment or provided services which is the subject of a cause of action by a participant or beneficiary under paragraph (1) may not be appointed (or deemed to be appointed) as a designated decisionmaker under this paragraph with respect to such participant or beneficiary.

''(F) FAILURE TO APPOINT.—With respect to any cause of action under paragraph (1) relating to a denial of a claim for benefits where a designated decisionmaker has not been appointed in accordance with this paragraph, the plan sponsor or named fiduciary responsible for determinations under section 503 shall be deemed to be the designated decisionmaker.

''(G) EFFECT OF APPOINTMENT.—The appointment of a designated decisionmaker in accordance with this paragraph shall not affect the liability of the appointing plan sponsor or named fiduciary for the failure of the plan sponsor or named fiduciary to comply with any other requirement of this title.

''(H) TREATMENT OF CERTAIN TRUST FUNDS.—For purposes of this subsection, 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.).

''(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

''(A) IN GENERAL.—Paragraph (1) shall apply only if—

''(i) a final determination denying a claim for benefits under section 503B has been referred for independent medical review under section 503C(d) and a written determination by an independent medical reviewer has been issued with respect to such review, or

''(ii) the qualified external review entity has determined under section 503C(c)(3) that a referral to an independent medical reviewer is not required.

''(B) INJUNCTIVE RELIEF FOR IRREPARABLE HARM.—A participant or beneficiary may seek relief under subsection (a)(1)(B) prior to the exhaustion of administrative remedies under section 503B or 503C (as required under subparagraph (A)) if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Any determinations that already have been made under section 503A, 503B, or 503C in such case, or that are made in such case while an action under this subparagraph is pending, shall be given due consideration by the court in any action under subsection (a)(1)(B) in such case. Notwithstanding the awarding of such relief under subsection (a)(1)(B) pursuant to this subparagraph, no relief shall be available under paragraph (1), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS 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 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.

''(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

''(A) MAXIMUM AWARD OF NONECONOMIC DAMAGES.—The aggregate amount of liability for noneconomic loss in an action under paragraph (1) may not exceed $1,500,000.

''(B) LIMITATION ON AWARD OF PUNITIVE DAMAGES.—In the case of any action commenced pursuant to paragraph (1), the court may not award any punitive, exemplary, or similar damages against a defendant, except that the court may award punitive, exemplary, or similar damages (in addition to damages described in subparagraph (A)), in an aggregate amount not to exceed $1,500,000, if—

''(i) the denial of a claim for benefits involved in the case was reversed by a written determination by an independent medical reviewer under section 503C(d)(3)(F); and

''(ii) there has been a failure to authorize coverage in compliance with such written determination.

''(C) PERMITTING APPLICATION OF LOWER STATE DAMAGE LIMITS.—A State may limit damages for noneconomic loss or punitive, exemplary, or similar damages in an action under paragraph (1) to amounts less than the amounts permitted under this paragraph.

''(5) ADMISSIBILITY.—In an action described in subclause (I) or (II) of paragraph (1)(A) relating to a denial of a claim for benefits, any determination by an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) relating to such denial is admissible.

''(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section 503B(a)(4) by the group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, shall not be used in determining liability.

''(7) LIMITATIONS ON ACTIONS.—Paragraph (1) shall not apply in connection with any action that is commenced more than 5 years after the date on which the failure described in such paragraph occurred or, if earlier, not later than 2 years after the first date the participant or beneficiary became aware of the personal injury or death referred to in such paragraph.

''(8) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to a directed record keeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed record keeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan, the employer, or another plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not

include making determinations on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(9) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this subsection shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. A cause of action that is based on or otherwise relates to a group health plan's determination on a claim for benefits shall not be deemed to be the delivery of medical care under any State law for purposes of this paragraph. Any such cause of action shall be maintained exclusively under this section. Nothing in this paragraph shall be construed to alter, amend, modify, invalidate, impair, or supersede section 514.

''(10) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by a fiduciary which consists of full compliance with the reversal under section 503C (relating to independent external appeals procedures for group health plans) of a denial of claim for benefits (within the meaning of section 503C(i)(2)).

''(11) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage.

''(12) LIMITATION ON CLASS ACTION LITIGATION.—A claim or cause of action under this subsection may not be maintained as a class action, as a derivative action, or as an action on behalf of any group of 2 or more claimants.

''(13) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

''(14) RETROSPECTIVE CLAIMS FOR BENEFITS.—A cause of action shall not arise under paragraph (1) where the claim for benefits relates to an item or service that has already been provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(15) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(16) DEFINITIONS AND RELATED RULES.—For purposes of this subsection:

''(A) CLAIM FOR BENEFITS.—The term 'claim for benefits' shall have the meaning given such term in section 503A(e).

''(B) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a).

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1).

''(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(E) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

''(F) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(G) TREATMENT OF EXCEPTED BENEFITS.—The provisions of this subsection (and subsection (a)(1)(C)) shall not apply to excepted benefits (as defined in section 733(c)), other than benefits described in section 733(c)(2)(A), in the same manner as the provisions of part 7 do not apply to such benefits under subsections (b) and (c) of section 732.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking ''or'' at the end of subparagraph (A);

(B) in subparagraph (B), by striking ''plan;'' and inserting ''plan, or''; and

(C) by adding at the end the following new subparagraph:

''(C) for the relief provided for in subsection (n) of this section.''.

(b) AVAILABILITY OF ACTIONS IN STATE COURT.—

(1) JURISDICTION OF STATE COURTS.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)) is amended—

(A) in the first sentence, by striking ''subsection (a)(1)(B)'' and inserting ''paragraphs (1)(B), (1)(C), and (7) of subsection (a)'';

(B) in the second sentence, by striking ''paragraphs (1)(B) and (7)'' and inserting ''paragraphs (1)(B), (1)(C), and (7)''; and

(C) by adding at the end the following new sentence: ''State courts of competent jurisdiction in the State in which the plaintiff resides and district courts of the United States shall have concurrent jurisdiction over actions under subsections (a)(1)(C) and (n).''.

(2) LIMITATION ON REMOVABILITY OF CERTAIN ACTIONS IN STATE COURT.—Section 1445 of title 28, United States Code, is amended by adding at the end the following new subsection:

''(e)(1) A civil action brought in any State court under subsections (a)(1)(C) and (n) of section 502 of the Employee Retirement Income Security Act of 1974 against any party (other than the employer, plan, plan sponsor, or other entity treated under section 502(n) of such Act as such) arising from a medically reviewable determination may not be removed to any district court of the United States.

''(2) For purposes of paragraph (1), the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 503C(d)(2) of the Employee Retirement Income Security Act of 1974.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions, from which a cause of action arises, occurring on or after the applicable effective date under section 601.

Amend section 403 to read as follows:

SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402, is further amended by adding at the end the following:

''(o) LIMITATION ON CLASS ACTION LITIGATION.—Any claim or cause of action that is maintained under this section (other than under subsection (n)) or under section 1962 or 1964(c) of title 18, United States Code, in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to actions commenced on or after August 2, 2001. Notwithstanding the preceding sentence, with respect to class actions, the amendment made by subsection (a) shall apply with respect to civil actions which are pending on such date in which a class action has not been certified as of such date.

Amend section 603 to read as follows:

SEC. 603. SEVERABILITY.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), if any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

(b) DEPENDENCE OF REMEDIES ON APPEALS.—If any provision of section 503A, 503B, or 503C of the Employee Retirement Income Security Act of 1974 (as inserted by section 131) or the application of either such section to any person or circumstance is held to be unconstitutional, section 502(n) of such Act (as inserted by section 402) shall be deemed to be null and void and shall be given no force or effect.

(c) REMEDIES.—If any provision of section 502(n) of the Employee Retirement Income Security Act of 1974 (as inserted by section 402), or the application of such section to any person or circumstance, is held to be unconstitutional, the remainder of such section shall be deemed to be null and void and shall be given no force or effect.

Page 16, line 10, strike ''on a timely basis'' and insert ''in accordance with the applicable deadlines established under this section and section 503B''.

Page 29, line 14, strike ''or modify''.

Page 36, line 12, strike ''upheld, reversed, or modified'' and insert ''upheld or reversed''.

Page 39, line 23, strike ''uphold, reverse, or modify'' and insert ''uphold or reverse''.

Page 40, line 8, and page 44, line 9, strike ''or modify''.

Page 23, line 18; page 41, line 19; page 43, line 2; , , strike ''reviewer (or reviewers)'' and insert ''a review panel''.

Page 33, line 7, strike ''reviewer'' and insert ''review panel''.

Page 34, line 25, strike ''reviewer'' and insert ''review panel composed of 3 independent medical reviewers''.

Page 34, lines 8 and 13; page 36, line 8; page 37, line 3; page 38, lines 6 and 20; page 39, line

4, 20, and 21; page 40, lines 1, 2 and 14; page 41, line 6; page 43, lines 6, 17, and 20; page 44, lines 5, 9, and 14; page 45, line 24; page 61, line 5; page 67, line 3; page 68, line 25; , strike ''reviewer'' and insert ''review panel''.

Page 36, line 14; page 43, line 21; page 44, line 12; , strike ''reviewer's'' and insert ''review panel's''.

Page 41, line 4, strike ''reviewer (or reviewers)'' and insert ''review panel''.

Page 47, line 15, strike ''independent external reviewer'' and insert ''independent medical review panel''.

Page 50, line 20, strike ''1 or more individuals'' and insert ''an independent medical review panel''.

Page 51, amend lines 4 through 6 to read as follows:

''(B) with respect to each review, the review panel meets the requirements of paragraph (4) and at least 1 reviewer on the panel meets the requirements described in paragraph (5); and

Page 51, line 8, strike ''the reviewer'' and insert ''each reviewer''.

Page 53, line 21, strike ''a reviewer'' and insert ''each reviewer''.

Page 54, line 6, strike ''a reviewer (or reviewers)'' and insert ''the independent medical review panel''.

Page 61, line 5, insert ''or any independent medical review panel'' after ''reviewer''.

Page 64, lines 1 and 5, strike ''reviewers'' and insert ''review panel''.

Page 64, line 14; page 69, lines 16 and 19, strike ''reviewers'' and insert ''review panels''.

Page 8, after line 17, insert the following (and place the text from page 8, line 18, through page 16, line 20 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 503 (29 U.S.C. 1133) the following:

''SEC. 503A. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

Page 16, after line 21, insert the following (and place the text from page 16, line 22, through page 25, line 13 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by section 102) is amended further by inserting after section 503A (29 U.S.C. 1133) the following:

''SEC. 503B. INTERNAL APPEALS OF CLAIMS DENIALS.

Page 25, after line 15, insert the following (and place the text from page 25, line 16, through page 69, line 22 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by sections 102 and 103) is amended further by inserting after section 503B (29 U.S.C. 1133) the following:

''SEC. 503C. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

Page 119, line 1, insert after ''treatment.'' the following: ''The name of the designated decisionmaker (or decisionmakers) appointed under paragraph (2) of section 502(n) of the Employee Retirement Income Security Act of 1974 for purposes of such section.''.

Page 138, line 21, insert after ''plan'' the following: ''and only with respect to patient protection requirements under section 101 and subtitles B, C, and D and this subtitle''.

Page 145, line 12, strike ''and the provisions of sections 502(a)(1)(C), 502(n), and 514(d) of the Employee Retirement Income Security Act of 1974 (added by section 402)''.

Page 148, line 15, after ''Act'' insert the following: ''and sections 503A through 503C of the Employee Retirement Income Security Act of 1974''.

Page 149, line 9, after ''Act'' insert the following: ''and sections 503A through 503C of the Employee Retirement Income Security Act of 1974 (with respect to enrollees under individual health insurance coverage in the same manner as they apply to participants and beneficiaries under group health insurance coverage)''.

Page 152, line 16, insert ''section 101 and subtitles B, C, D, and E of'' before ''title I''.

Page 155, strike lines 1 through 19 (and redesignate the subsequent paragraphs accordingly).

Page 158, strike lines 19 through 25 and insert the following:

''(b)(1)(A) Subject to subparagraphs (B) and (C), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of sections 503A, 503B, and 503C, and such requirements shall be deemed to be incorporated into this subsection.

''(B) With respect to the internal appeals process required to be established under section 503B, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(C) Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external review entity for the conduct of external appeal activities in accordance with section 503C, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(2) In the case of a group health plan, compliance with the requirements of sections 503A, 503B, and 503C, and compliance with regulations promulgated by the Secretary, in connection with a denial of a claim under a group health plan shall be deemed compliance with subsection (a) with respect to such claim denial.

''(3) Terms used in this subsection which are defined in section 733 shall have the meanings provided such terms in such section.''.

Page 210, line 19, after ''Act'' insert the following: ''and sections 503A through 503C of the Employee Retirement Income Security Act of 1974''.

Make such additional technical and conforming changes to the text of the bill as are necessary to do the following:

(1) Replace references to sections 102, 103, and 104 of the bill with references to sections 503A, 503B, and 503C of the Employee Retirement Income Security Act of 1974, as amended by the bill.

(2) In sections 102, 103, and 104, strike any reference to ''enrollee'' or ''enrollees'' and insert ''in connection with the group health plan'' after ''health insurance coverage'', and make necessary conforming grammatical changes.

The CHAIRMAN. Pursuant to House Resolution 219, the gentleman from Georgia (Mr. NORWOOD) and a Member opposed each will control 30 minutes.

Mr. ANDREWS. Mr. Chairman, I claim the time in opposition to the amendment.

The CHAIRMAN. The gentleman from New Jersey will be recognized for 30 minutes.

The gentleman from Georgia (Mr. NORWOOD) is recognized on his amendment.

Mr. NORWOOD. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today to bring before the House an effort at bridging the gap on this very difficult and contentious issue. I realize that my decision to bring forth this amendment is a controversial one, but I hope my colleagues will set aside for an hour their bitterness and consider the substance of our proposal.

I have heard some of my colleagues come to the floor to say that my amendment was written by the insurance industry. It is just silly, I think, for people to say that. The insurance industry cannot stand me. They have had me on dart boards for years, and everyone in the House knows that. So let us set aside those insane accusations. Instead, Mr. Chairman, let us talk about the substance of the amendment.

My amendment is consistent with the principles of the underlying bill. My amendment creates a cause of action for a negligent denial of a claim for benefits. This cause of action against insurers will be heard in State court. So does the underlying bill.

The amendment protects employers by allowing them to have a designated decisionmaker to be liable. So does the underlying bill.

□ 1845

It requires all administrative remedies be exhausted before a case can go to court. So the underlying bill, my amendment only allows punitive damages in cases where the insurer refuses to follow the determination of the external reviewer. So does the underlying bill.

There are, however, some significant differences. My amendment caps liability at $1.5 million for noneconomic damages. Punitive damages are capped at $1.5 million. I argued long and hard with almost every friend I have against putting caps in a bill for 4 years because we had a President who said he would veto a patient protections bill with caps. Now we have a President who says he will veto a bill without caps.

This compromise is a simple recognition of political reality. I have made a compromise to create a rebuttal presumption in favor of the insurer when the external reviewers rule in favor of the plan.

I have listened to my colleagues complain long and loud about the inequity of that, but I have one simple question in response: If the external reviewer says the plan was right in turning down a treatment, how could the plan have been negligent in turning down a treatment?

I know some of my colleagues feel I have made a significant change moving away from the simple lifting of the ERISA preemption, but before Members condemn differences because they are changes, think about what has really changed. Under my amendment, a patient will have a cause of action against an insurer in every State in America, in a State court using State

rules and procedures. Is that significantly different from the underlying bill?

I know some of my colleagues believe that the language of my amendment preempts the direction of current case law. We worked deep into the night last night on that language. I am not completely satisfied with the provision in our bill that protects State law, and I pledge to Members to work to further clarify the language in conference because I know Members know my intent.

But before Members offhandedly reject the language, I think they should explain to us how Americans will be left without a remedy under this amendment.

Mr. Chairman, the key difference between the amendment I am bringing before Members today and the underlying bill is that the President has agreed to sign the bill with the amendment I am bringing today. With all due respect to the gentleman from Kentucky, the amendment I bring today is a significant departure from the Fletcher bill.

The President has moved our way. I know this is not the ideal way to offer a potential hand of compromise. I really would not blame Members if they voted against the amendment, our Democratic friends, solely because of the process issue. But before slapping away the hand that is being extended to us, Members, I hope, will consider the substance and realize how close we truly are to a law, not a bill. We have done that, folks. But a law.

Mr. Chairman, I reserve the balance of my time.

Mr. ANDREWS. Mr. Chairman, I yield 2½ minutes to the gentleman from Texas (Mr. TURNER), a Member who understands the flaws of writing a complicated bill overnight.

Mr. TURNER. Mr. Chairman, we have heard a lot today from the other side about the need for balance between giving patients protections and holding down the cost of health insurance premiums.

In Texas, we have had 4 years of experience under our patient protection laws. Health insurance premiums in Texas have gone up at less than half the national average, 1,400 patients have exercised their right to appeal, and only 17 lawsuits have occurred.

The original Ganske-Dingell-Norwood bill is modeled after the Texas law. I submit to Members, in Texas, it is working. The Norwood amendment that is offered here today destroys that balance and tips the scales of justice in favor of the insurance companies.

Let us look at what the Norwood amendment does to the Ganske-Dingell-Norwood bill. First, it establishes procedural rules that favor the insurance company. For example, if the external review panel makes a ruling and you decide as a patient to appeal it, you go into court with the legal presumption that the medical review panel is correct. And to overcome that, patients have to do it by clear and convincing evidence, not the usual preponderance of the evidence in most civil cases.

Secondly, the Norwood amendment imposes this cap on noneconomic damages. The gentleman from Florida mentioned that the President would not sign a bill without a noneconomic damages cap. That is unusual because when the President pushed tort reform in Texas in 1995, there was no cap on noneconomic damages. In Texas today, there are no caps on noneconomic damages in lawsuits brought against HMOs.

Thirdly, the Norwood amendment grants the HMO industry special protection from accountability that no other business or industry in this Nation has to date.

Fourth, the Norwood amendment requires patients to prove that the wrongful and negligent acts of the HMO are the proximate cause of their injury rather than a proximate cause of the injury, as in the underlying bill. Some Members might ask, What is the big deal, ''A'' or ''the''? Very simple.

In a case involving an automobile accident, somebody runs a red light, causes an accident, it is pretty easy to say that the running of the red light is the proximate cause of the injury. But in malpractice cases, there is seldom a single cause of an injury.

Consider a woman with breast cancer. Her HMO denies her a mammogram which would have detected the nodule, she gets cancer and dies. The family brings a lawsuit against the HMO. The truth of the matter is, if we go with the Norwood amendment requiring the proximate cause, she would not recover. Her family would not recover because the proximate cause of her death was the cancer. So ''a proximate cause'' is what the law should say.

We need to make sure that the Norwood amendment is defeated.

Yet under the Norwood amendment, state laws like the Texas Patient Protection Law are preempted and patients end up in federal court with less protection.

It leaves the doctor at a disadvantage when the doctor is subject to a malpractice lawsuit along with an HMO. The claim against the doctor would be in state court under state law. The suit against the HMO would be under federal law and in every event would be subject to more favorable procedural protections. When HMOs make medical decisions they should have no less accountability than doctors must face in this country today.

The Norwood amendment is worse than current law in a lot of ways. It rolls back the protections that have been given to patients and their doctors in both statutory and common law. Why should we turn our backs on the original Ganske-Dingell-Norwood-Berry bill that has already passed in a bipartisan fashion in the Senate, a bill that passed this House in October of 1999 by an overwhelming majority of the House.

Mr. NORWOOD. Mr. Chairman, I yield 30 seconds to the gentleman from Arizona (Mr. SHADEGG).

Mr. SHADEGG. Mr. Chairman, my colleague from the other side said this was modeled, the Ganske-Dingell bill was modeled after the Texas law, and it was a wonderful bill.

Mr. Chairman, I wonder if the gentleman has read page 167 of the bill which provides to certain health care plans sponsored by very large group providers absolute immunity for nonmedical injuries? The language of the gentleman's bill says if there is a self-funded, self-insured plan, it gets absolute immunity when someone is injured or killed by a nonmedical determination.

So let us say they wrongfully decide coverage and a patient is injured, there is absolute immunity, there is no recovery whatsoever.

Mr. NORWOOD. Mr. Chairman, I yield 3 minutes to the gentleman from Minnesota (Mr. PETERSON).

(Mr. PETERSON of Minnesota asked and was given permission to revise and extend his remarks.)

Mr. PETERSON of Minnesota. Mr. Chairman, I rise today to support the Norwood amendment. I first started working on a patient protections bill back in September 1992 when I introduced what I think was the first patient protection legislation in the House, H.R. 6027.

Among other things, it tried to make sense out of the way that ERISA impacted health services in this country. I have been working on these issues ever since.

It seems to me that we have finally reached the point where both sides in this debate have moved enough towards the middle we might be able to finally resolve these issues. The Fletcher-Peterson bill that I have been involved in has helped move everyone toward the center.

When the Senate was doing their bill, the Senate passed amendments that moved their bill toward the Fletcher-Peterson position. During the last few days, the Ganske-Dingell bill has added language to cover some of these same provisions, such as including the dedicated decision-maker language, requiring the full exhaustion of internal and external reviews before going to court, keeping contract disputes in Federal courts and making adjustments to MSAs.

The patients' rights issue has come a long way since 1992 when we first started on this. Last night we continued that progress with the gentleman from Georgia (Mr. NORWOOD) helping to put together a compromise that we could actually pass into law. Last night, to the credit of the gentleman from Georgia (Mr. NORWOOD) and President Bush, each gave a little to get a little, and the product of that compromise is what we have before us today.

But are we grateful for this compromise? Are we praising everyone for having reached an agreement that is essentially the majority of the base bill itself? No. Instead, now, we have shifted the argument to other issues, like preemption of State law.

As I understand it, the Ganske-Dingell bill develops a State cause of action in that it modifies it with things

such as a dedicated decision-maker and other things which are a preemption of State law, as far as I can see. That leaves us with the question of whether or not, if we are doing that, it is constitutional.

Can we make Federal conditions on a State cause of action, and is this not preemption of State law? The Norwood amendment has created a Federal cause of action modified in the same ways. I think it is more workable, and I think clearly it will withstand the test of constitutionality.

With regard to the liability provisions, as a result of the negotiation with the President, the Norwood amendment increased the caps on damages to $1.5 million from the $500,000 that was advocated in the Fletcher-Peterson bill.

The Norwood amendment will protect small businesses and mitigate against possible increases of uninsured, as well as improving, health care delivery. This amendment finally moves H.R. 2563 to a place of agreement, a place where the Patients' Bill of Rights can pass the House; and if the other body is willing to work with us in good faith, we can ultimately get the President's signature and put this legislation into law.

Mr. Chairman, I encourage each and every one of my colleagues to support a real solution to the issue of patients' rights. Support the Norwood amendment.

Mr. ANDREWS. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. WAXMAN), who is a champion of consumer groups across the Nation that strongly oppose the Norwood amendment.

(Mr. WAXMAN asked and was given permission to revise and extend his remarks.)

Mr. WAXMAN. Mr. Chairman, I am sorry to say it is hard to escape the conclusion that last night President Bush finally put so much pressure on the gentleman from Georgia (Mr. NORWOOD) that in the words of the New York Times editorial today he, quote, ''apparently sold out his own cause.'' That is sad for Americans who need and deserve a strong and enforceable Patients' Bill of Rights.

Mr. Chairman, I just want to review what the American Medical Association concluded about the deal agreed to by their former ally: It overturns the good work done by States in protecting patients; it reverses developing case laws that allow patients to hold plans accountable when they play doctor. In other words, it makes things worse instead of better for patients. It provides patient protections, but does not allow enforcement of those rights.

If the White House operatives thought they could defend the so-called ''compromise'' President Bush talked the gentleman from Georgia (Mr. NORWOOD) into, why did they insist that he make a commitment without talking it over with his allies in and out of the government? Why did they insist that drafting be rushed through in the wee hours of the morning, and insist that they move forward before consumer and physician groups and the American public could see and understand the provisions?

Why do we find ourselves here on the House floor voting on an amendment that either deliberately or accidentally preempts State laws, disadvantages patients, and provides HMOs with a presumption that they are right and the patient and physicians are wrong.

Mr. Chairman, I think the answer is obvious. They knew that if people really got a chance to look at this, they would see it for the sham that it is.

This is not the way to enact a Patients' Bill of Rights. This is the way to ensure another stalemate. Reject this amendment.

□ 1900

Mr. NORWOOD. Mr. Chairman, everybody knows that the New York Times is not all of our Bible. They get it wrong frequently. They even reported I lost 60 pounds; and you know darn well it was 40, so they do not get it right.

Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. BARTON).

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Chairman, my father was a combat navigator in World War II. He flew a B–24 liberator on 50 combat missions. He won every combat award the Army Air Corps could award except the Congressional Medal of Honor. I am glad he did not win that one or I would not be here.

When I got elected to Congress I went to him and I asked him for some advice.

I said: Dad, what should I do when I get up there?

He said: Son, always pick a good pilot.

I said: Pick a good pilot. What do you mean?

He said: There are going to be lots of rascals in Washington and they're going to try to flimflam you; but if you've got a good pilot, he'll set the right course and he'll always get you home.

Last week the gentleman from Georgia (Mr. NORWOOD) was the toast of the town on the liberal side because he was holding out for the Patients' Bill of Rights. He negotiated an agreement with the White House and President Bush which I have looked at this afternoon, it looks pretty good to me, and all of a sudden today he is accused of selling out.

Mr. Chairman, the gentleman from Georgia is a good pilot. I would fly with him anywhere. The day the gentleman from Georgia sells out is the day ''In God We Trust'' that is on the facade behind us falls off that facade.

I am with the gentleman from Georgia, I am going to vote for this bill, and I say God bless the gentleman from Georgia, he is a good man.

Mr. ANDREWS. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. PALLONE), who represents a State that just enacted a very strong patient protection law that will be repealed by this amendment.

Mr. PALLONE. Mr. Chairman, when you are sick and you have been denied care and often do not have the energy to fight, the Norwood amendment puts all sorts of roadblocks in the way of a real independent review. The real Patients' Bill of Rights allows you to quickly and informally go to an independent review board. They look at the patient, they look at the medical record, look at whatever they want and decide what care you need. Norwood turns this around and puts roadblocks in your way. It makes it a judicial-type procedure stacked against you. The HMO picks the information it sends to the board, the patient has no right to see it and no right to ask witnesses any questions. You will need a lawyer under Norwood in order to make your case. You have to prove that the HMO's decision was wrong and should be either affirmed or overturned. There is no flexibility with the board to craft a plan of care somewhere in between.

Worse, if the board agrees with the HMO, a presumption in favor of the HMO makes an appeal to the courts almost impossible.

Norwood stacks the deck against you. And it gives all the cards to the HMO.

Mr. ANDREWS. Mr. Chairman, I yield 4 minutes to the gentleman from Iowa (Mr. GANSKE), one of the two principal authors of this bill.

Mr. GANSKE. Mr. Chairman, I thank the gentleman for yielding time.

Here we are. This is the nitty-gritty of the debate. We have sort of been fooling around until we get to the Norwood amendment.

My colleague from Georgia is an acknowledged expert on this issue. I wonder if my colleague would clarify some issues for me.

The gentleman from Georgia (Mr. NORWOOD) last night at the Committee on Rules agreed that he had said that, quote, ''HMOs will be treated better than others in the Norwood amendment.''

Is that because HMOs are being given affirmative defenses?

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to the gentleman from Georgia.

Mr. NORWOOD. Because there is no way that you can make it exactly the same between the physician and the HMO, I do not believe. If the gentleman is talking about the rebuttable presumption, and I presume he is, what I would say to him there is that I did the best I could do in negotiations to continue to allow the patient to have the recourse to going into court.

Mr. GANSKE. But it is fair to say, then, that he stands by his statement?

Mr. NORWOOD. I stand by the fact that if an insurance company does exactly what they are told to do by a group of physicians in the external review model, then we have to encourage them to offer the treatment and not put them in a position so that they have always the fear of being drug into court. But as the gentleman knows, I agree that that patient should have the right to go into court.

Mr. GANSKE. So he stands by his statement that HMOs are treated better in his amendment than others.

Now, is it the gentleman's understanding that his bill would abrogate State laws on patients' rights?

Mr. NORWOOD. It is my understanding and the intent of this bill that, first of all, we have a Federal cause of action for denial of care or the delay of care in State court. We intend, and it is going to be this way before we get it out of that conference if there is any question about it, because the gentleman knows how it is with lawyers: ''is'' doesn't mean ''is.'' One lawyer says it means this; another lawyer says it means that. But our intent is not to preempt any cause of action at the State level.

Mr. GANSKE. Let me just read to the gentleman a statement by Ari Fleischer today on this issue. The question to him was:

Republicans and Democrats believe that the deal struck between Mr. NORWOOD and the President would abrogate State laws on patients' bill of rights. Is that the White House understanding?

Here is what Mr. Fleischer said:

Yes. Yes. And I think you can get into a good discussion of that at the background.

Question: So he doesn't believe that it would not abrogate State laws?

Fleischer: There are a certain series of preemptions in there.

Does the gentleman agree with Mr. Fleischer's assessment there?

Mr. NORWOOD. In some States that presently have a managed care, an HMO reform bill, we are going to have a preemption and a replacement in that.

Mr. GANSKE. The gentleman from Georgia has respected the opinion of Sara Rosenbaum, David Frankfurt and Rand Rosenblatt. He has sent out Dear Colleagues on them. This is what they have to say about the Norwood amendment:

''In preempting State law, the Norwood amendment goes beyond conduct that involves negligent medical judgment to a particular patient's case. The amendment made by virtue of the words ''based on'' stipulate that State malpractice law does not apply to any treatment decision made by the managed care organization, whether it be negligent, reckless, willful or wanton. For example,'' Rosenbaum continues, ''no State cause of action could be maintained against a designated decisionmaker for its decision to discharge a patient early from a hospital even if the likely result of that discharge would result in a patient's death. In short, all forms of vicarious liability under State law would be preempted.''

Is that an accurate representation?

Mr. NORWOOD. The key word here is ''may.'' We do not believe that it does that. We do not intend for it to do that. And I do not intend for it to do that when we have the opportunity to get into conference.

Mr. GANSKE. I thank the gentleman.

Mr. NORWOOD. Mr. Chairman, I yield 2 minutes to the gentleman from Georgia (Mr. ISAKSON).

Mr. ISAKSON. Mr. Chairman, our State's motto is ''Wisdom, Justice and Moderation.'' A favorite son of ours today, Dr. CHARLES NORWOOD, exhibited those three qualities and those three characteristics absolutely.

I do not think a thing in the world I am going to do is going to change a mind in here, what I say; but I hope maybe we will get back and change our hearts for just a second.

My granddaddy had a saying in south Georgia when he got into a confusing controversy. He said, ''You know, if you want to get the mud out of the water, you've got to get the hogs out of the spring.''

We are at a point in this debate where the focus on self-interest of all the diverse interests on this bill is clouding the water. We have made steps forward in patients' rights. We have made steps forward in the amount that can be received in noneconomic and punitive damages. We have made steps forward in protecting the fact that Americans are still going to have insurance and joint and several liability will not sweep through American business.

Some can poke fun at the gentleman from Georgia if they like, and you can ask me hard questions I cannot answer; but successful legislation in America on behalf of the people we are here to represent who are our citizens, are going to be the patients, are better than the muddy water interests of any lawyer, any business employer, any physician, any HMO or any insurance company.

There comes a time and a place for a man to do what is right. Dr. CHARLES NORWOOD has done what is right. You may disagree, but we are light years ahead of where we have ever been; and we owe this debate better than some of the things that have been said.

I urge your support for the Norwood amendment.

Mr. ANDREWS. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. GREEN) to comment on the bill that is before us rather than the one he wishes was before us.

Mr. GREEN of Texas. Mr. Chairman, first I want to say that I respect the gentleman from Georgia (Mr. NORWOOD) and the hard work that he has done; but I also disagree with the language that was agreed to, and I can stand here on this floor and still respect him but disagree with him.

The President and the gentleman from Georgia stood last night on the podium and proclaimed they reached a compromise. But it is really not a compromise. It is not a compromise because not everybody was involved. Only one Member was involved in it. The Norwood amendment holds HMOs to different standards than doctors and hospitals. That was the base reason for the bill. We are going to hear lots of Members come up tonight and talk about how this is a great bill, but they were for the Fletcher bill. They were not for a real patients' bill of rights, anyway. So we are going to hear that tonight. Even though HMOs act like doctors if they deny or delay care, they are not held accountable like doctors under this amendment. They are the only health care providers that are shielded. That is what is wrong.

What is more troubling about this proposal is that it destroys the important patient protections that we have had in Texas for 4 years. The gentleman from Arizona (Mr. SHADEGG) may quote Texas law, but the amendment that the gentleman from Georgia negotiated with the President goes against Texas law. It does not have anything to do with holding an employer who runs the business. That is Texas law. We wanted to correct that in this bill. But it does change the liability. And it does change the presumption.

There is nothing in Texas law that gives the HMO or the insurance company the presumption that they are right. That is wrong. That is why our appeals are so successful in Texas. That is why 52 percent of the 1,400 appeals were in favor of the patient. The HMOs that you are defending were wrong more than half the time. That is what is wrong with this law. That is why it is so bad. It is going to hurt what we have successfully done in Texas where the insurance policies are under State law. But we need to do a real patients' bill of rights for everyone in the country. Sixty percent of my constituents do not come under Texas law; they come under ERISA. That is why we need to make sure we pass a strong patients' bill of rights, not a patients' bill of wrongs, not an HMO bill of rights. That is what this is.

You heard the gentleman from Texas (Mr. TURNER) talk about just the changing of an ''a'' to a ''the'' will make sure our patients are shafted by this bill.

Mr. ANDREWS. Mr. Chairman, I am pleased to yield 1½ minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Chairman, let me simply say I am trained as a lawyer. But today I stand on this floor as someone who has been, as many of us, a patient. I would like to cast my lot with the physicians. And though I agree with the gentleman, I do not want a bill; I would like to have a law. But I am prepared as a patient

fight to the last breath so that patients around the country can have the privilege of knowing that decisions between them and their physician are not interfered with by HMOs.

I know the gentleman from Georgia means well and we do respect him. But his amendment interferes and puts a wedge between the patient-physician relationship. Our people understand what is right and what is wrong. Under the presumption in his amendment, patients are wrong, physicians are wrong and HMOs are right. Interestingly enough, the George Washington University in a letter dated today said that this amendment stipulates that State malpractice law does not apply to any treatment decision made by a managed care organization whether it be negligent, reckless, willful or wanton.

Picture yourself in a relationship with a doctor. They recommend a diagnosis; they ask for a procedure. And there you are with an HMO that denies it, recklessly, willfully and wantonly and God help that you live and if you do not, look at your relatives going in to challenge them, not because they want to be in court but because they want to right the wrong and the HMO stands as the right and you stand as the wrong.

I fight for the patients, and I fight for the physicians. I think this amendment should go down.

□ 1915

Mr. NORWOOD. Mr. Chairman, I yield 2 minutes to my lawyer, the gentleman from Arizona (Mr. SHADEGG).

Mr. SHADEGG. I thank the gentleman for yielding me time.

Mr. Chairman, let me begin by saying I respect greatly our colleague, the gentleman from Iowa (Mr. GANSKE), who has worked very hard on this bill; but I think it is important to note he talked about the issue of affirmative defenses. In the negotiations between the gentleman from Georgia (Mr. NORWOOD) and the President, all of the affirmative defenses were stricken from the bill because the gentleman from Georgia (Mr. NORWOOD) wanted them stricken and they are gone.

Let us talk about this, the other issue of preemption. I need to talk about preemption, because a great deal has been made here. Let us talk about the issue of preemption, because that seems to be of great concern here.

It needs to be understood that, number one, ERISA today preempts a claim for benefits in all 50 States. If you try to bring a claim for benefits and bring that as a cause of action in State court, you cannot bring it in a single State, including Texas. Indeed, the corporate healthcare case, Corporate HealthCare v. Texas right here, says specifically that. If you seek to bring a claim for benefits case in State court, it is preempted by Federal law.

There is a good reason for that. It is so that the management of claims in all 50 States can be uniform, because this law, ERISA, was intended to govern multi-State employers and multi-State unions.

Now, let us talk about a second issue, that is the Ganske bill. They would have you believe that the Norwood amendment is the only thing that preempts anything. That is ridiculous. The Ganske-Dingell bill preempts issue after issue within the State cause of action. It says you can bring a State cause of action, but then it preempts pieces of that. It says you can only bring it against a designated decision-maker, it says you can only bring it after exhausting external review. The preemption issue is in your bill as well as our bill, although it is 19 pages long in your bill.

Let us talk about its effort at preemption in this bill. In this bill, we say what current law says, and that is if you are bringing a claim for benefits, that belongs in Federal court. But, do you know what? We give a remedy for damages.

But we also go beyond and codify existing State law on the issue of the claims you can bring in States. If you bring a negligence claim against a plan or its doctor, you can bring that for the services they delivered, you can bring that under existing State law, and this bill specifically says you can continue to bring it.

This is a red herring. I urge the adoption of the Norwood amendment.

Mr. ANDREWS. Mr. Chairman, I yield myself 15 seconds.

I believe the gentleman from Arizona said affirmative defenses are not spelled out in the Federal cause of action. That is right. Of course, that means it is up to the judiciary to invent them as we go along. We do not know whether there will be affirmative defenses or not, what they will mean, because it is not included in here. Because when you draft a cause of action overnight, you cannot think of those things.

Mr. Chairman, I yield 1 minute to the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Chairman, I thank the gentleman for yielding me time.

Make no mistake, the Norwood amendment guts the patients' bill of rights, and what is left behind? Nothing more than an ''HMO Bill of Slights.''

The Norwood amendment slights patients with weakened accountability provisions; it slights patients by preempting stronger State laws, which would allow patients to sue HMOs for bad medical decisions; it slights patients by prohibiting class action lawsuits against HMOs; and it slights patients by allowing HMOs to delay a patient's day in court by choosing Federal court over State court.

Mr. Chairman, justice delayed is justice denied. The American people have waited too long for a real HMO bill of rights. Vote no on the Norwood amendment, the ''HMO Bill of Slights.''

Mr. NORWOOD. Mr. Chairman, I am pleased to yield 1 minute to the gentleman from Georgia (Mr. DEAL), a good friend of mine.

Mr. DEAL of Georgia. Mr. Chairman, I thank the gentleman for yielding me time.

As a trial attorney, I am both amused and somewhat dismayed by some of the things that have been said here today. First of all, as a trial attorney, it is amusing it see my good friend the plastic surgeon cross-examining my other good friend, a dentist. But be that as it may, there are a lot of things that have been said here.

First of all, on the issue of preemption, I think the gentleman from Arizona (Mr. SHADEGG) said it well. If States could do the things that we are seeking to do in this legislation, then let States to it. It is the very fact they cannot that is the necessity for the Federal legislation that we are attempting to put in place here today.

On behalf of my friend the gentleman from Georgia (Mr. NORWOOD), let me say this in conclusion. Many who would speak against his efforts have been here for decades and saw no reason to go forward with the effort of a patients' bill of rights, and to them I say, the gentleman from Georgia (Mr. NORWOOD) should be your hero.

For those who would denigrate his methods or motives, I would simply say to them, this issue would not be here today on the brink of becoming law had it not been for his dedication.

For those of you who think the gentleman from Georgia (Mr. NORWOOD) has sold out, it simply proves to me, you do not know the gentleman from Georgia (Mr. NORWOOD).

Mr. ANDREWS. Mr. Chairman, I yield 1 minute to the gentlewoman from California (Ms. LOFGREN), one of our advocates for a strong and forceful patients' bill of rights.

Ms. LOFGREN. Mr. Chairman, it has been quite a week here in the House of Representatives. On Tuesday, we made it a felony for scientists to cure disease with stem cells; Wednesday, we gave $36 billion in tax goodies to big oil, gas and others, and allowed drilling in national refuges; and today, we see the perversion of a good idea, a law that would protect patients from insurance companies has been transformed into a bill that protects insurance companies from patients.

The President's deal was obviously written by, or at least for, special interests. It would repeal California's responsible law and replace it with a new Federal preemption that would prevent wrongdoers who are insurers, even intentional wrongdoers, from being held responsible for their actions.

Now, why is it that doctors, lawyers, nurses can be held responsible for their wrongdoing, but not insurance companies? It looks to me that the bigger the campaign contributions to the Republicans, the bigger the payoff with laws to benefit those same contributors.

This body has morphed from a place where legislation is deliberated upon to the White House ATM machine. This

week, start by making scientists criminals; midweek, trash the environment; today, destroy the patients' bill of rights.

It is a good thing Congress is about to recess. I do not know if the country could stand another week like this one of Republican ''victories,'' where the special interests rule to the detriment of ordinary Americans.

Mr. ANDREWS. Mr. Chairman, we hear often about the benefits of the Texas patients' bill of rights, which will be repealed as a result of this amendment.

Mr. Chairman, I yield 1 minute to the gentleman from Texas (Mr. BENTSEN).

Mr. BENTSEN. Mr. Chairman, I thank the gentleman for yielding me time.

Mr. Chairman, let me start out by saying I have nothing but the highest respect for the gentleman from Georgia (Mr. NORWOOD). The problem is, the gentleman from Georgia (Mr. NORWOOD) went as far as could go, and he ran into the White House. It is ironic, after being here for 7 years, coming from a State where my former Governor used to say, let Texans run Texas, and where my Texas colleagues up here on the other side of the aisle said, let the States do it, because the States can do it better, what always happens, whenever it gets in the way of the powerful special interests, this idea of devolving power to the States becomes wholly inconvenient.

The bill before us today would upend the law in Texas that passed under George Bush's watch, the law he talked about during the campaign that he was so proud about. But the fact is, that it upends the interests of very powerful insurance companies who do not like the Texas law, they do not like the California law, they do not like the New Jersey law.

Now we are told we have to pass a bill in the House before conference so we can get to conference, and then the gentleman from Georgia (Mr. NORWOOD) has turned around and told us if there are problems with it, we will work it out in conference.

It all seems rather inconsistent. Defeat the Norwood amendment, and let us pass a real patients' bill of rights.

Mr. ANDREWS. Mr. Chairman, the American Medical Association, health care providers across the country, want the Norwood amendment defeated.

Mr. Chairman, I yield 1 minute to the gentlewoman from California (Ms. CAPPS), a representative of the nursing profession before she came here.

Mrs. CAPPS. Mr. Chairman, I rise in opposition to the Norwood amendment.

In the absence of action by the Federal Government, my State of California recently acted to protect its citizens from overzealous cost-cutters in the HMOs. One of the strengths of Ganske-Dingell is it creates a Federal floor for patient protections, allowing States like my own to have stronger protections.

But this amendment would override those State laws in order to protect HMOs from accountability. As was confirmed in an exchange just now between the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD), this amendment obliterates the cause of action defined by the State of California, my State, and so many other States as well.

If this amendment were to pass, patients in my home State would have fewer protections than they do right now, and HMOs in California would have more freedom to abuse them.

This amendment will do worse than take the teeth out of the Ganske-Dingell bill; it will take the teeth out of state protections. So I oppose the Norwood amendment, and I urge my colleagues to do the same.

Mr. NORWOOD. Mr. Chairman, it is my pleasure to yield 1 minute to my friend, the gentleman from New York (Mr. HOUGHTON).

Mr. HOUGHTON. Mr. Chairman, before I begin, I just want to thank a couple of people who have spent an enormous amount of time on this, Francesca Tedesco and also Kathy Rafferty. I want to thank the gentleman from Georgia (Mr. NORWOOD).

What the gentleman from Georgia (Mr. NORWOOD) has done is very, very significant. I say this because I come from the world of business. You can have a patient, you can have a patient's rights, but if you do not have the funding for that patient, it does not do any good.

What the gentleman from Georgia (Mr. NORWOOD) has done is bridge the gap and made it possible for those people, not only in large and small businesses, and small businesses, as you know, comprise 75 percent of the employment in this country, it enables them now to buy into a program which they feel they can afford, without having the sword of liability, unending liability, hanging over their head.

I think a lot of people are going to be thanking the gentleman from Georgia (Mr. NORWOOD) for bridging this gap, because it would not have happened without him.

Mr. ANDREWS. Mr. Chairman, I am pleased to yield 1 minute to the gentleman from Texas (Mr. SANDLIN), another Texan who does not want his State law repealed by the Norwood amendment.

Mr. SANDLIN. Mr. Chairman, I rise in strong opposition to this outrageous amendment. For patients, this amendment is a lose-lose situation. It is heads, the HMOs win, and tails, the patients lose.

Just a couple of points. This presumption, do you realize there is a rebuttable presumption that creates a hurdle so high that patients will never be able to recover? I have been in this situation before.

Do you know that courts will be giving written instructions to juries to say the insurance company won before and the insurance company ought to win again, and that is the burden you are putting on them.

You are also increasing the burden on punitives. You are making it outrageous. You are increasing it to clear and convincing. That will never happen.

The biggest fraudulent change of all was done in the dark of the night where the standard was changed from a proximate cause to the proximate cause. That was not done by accident, it was done to gut the entire bill. If someone dies from a heart attack, for example, and was denied treatment, the death will not be from the lack of treatment, it will be from the heart attack, and they lose.

This entire bill has been gutted. We all know what happened. We worked 5 years on this bill, and last night it was undone in a matter of minutes, and we know what happened.

Mr. ANDREWS. Mr. Chairman, I am pleased to yield 1½ minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Chairman, I rise in opposition to the Norwood amendment. It overturns the painstaking work that has been done over the past 5 years to craft a good piece of legislation that said that we are going to protect patients in this country, that we are going to protect their families.

It essentially establishes an HMO bill of rights. It affords insurance companies and HMOs a special status. It literally gives them the ability to act with impunity, that is, to make medical decisions that overrule doctors and harm patients; and, my friends, they never have to face the consequences of their actions.

It is the first time, and now legally the presumption is that the HMO is right, and you have to prove them wrong. That is what happened at the White House last night.

The Bush-Norwood amendment is just another example of President Bush siding with the special interests over hardworking American families by carving out special protections for the HMOs. This amendment rolls back patient protection, it walks all over States' rights.

My God, the other party is always talking about States making their decisions, individuals making the decisions, except when it conflicts with the rewards for their special interest friends.

Vote against the Norwood amendment.

Mr. ANDREWS. Mr. Chairman, I am pleased to yield 1 minute to the gentlewoman from Ohio (Mrs. JONES), a strong voice against special interest legislation.

Mrs. JONES of Ohio. Mr. Chairman, I rise in opposition to the Norwood amendment. It is very easy to speak in a vacuum about the impact that legislation has on the Federal level in State courts.

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But the reality is, with the lack of time dedicated to this particular legislation, we do not really know what in

heck it will have. In fact, we worry, and I am sure the gentleman from Georgia (Mr. NORWOOD) worries as well, that people's ability to bring claims in State courts have been, in fact, affected by this legislation.

Many of my colleagues may have had the opportunity to think about what happens in a courtroom, but I served in a courtroom for 10 years. One of the dilemmas about having legislation that is passed and saying in the State court, this is the impact we think it is going to have, is that it will ultimately take someone's case to work its way through the State court, through the appellate court, and then to the Supreme Court to resolve it.

So why, when we are people of good sense, can we not resolve it right here and understand and put in place legislation that will not have that type of impact?

Mr. Chairman, I rise in opposition to this legislation.

Mr. NORWOOD. Mr. Chairman, it is a pleasure to yield 1½ minutes to the gentleman from Tennessee (Mr. HILLEARY).

(Mr. HILLEARY asked and was given permission to revise and extend his remarks.)

Mr. HILLEARY. Mr. Chairman, I am a proud supporter of the Norwood amendment and I commend the gentleman from Georgia and the President last night for breaking the logjam on the Patients' Bill of Rights.

The Norwood amendment affects only liability. We are all in agreement on the medical care side of this debate. The only debate is over where the available money for health care will go, to the patients or the cost of litigation.

The Norwood amendment calls for full compensation to the patient for economic damages caused by an HMO. In other words, patients are completely compensated and reimbursed for the money the HMO actually caused them to lose. In addition, the Norwood amendment allows up to $3 million for pain and suffering and punitive damages. That is a lot of money, but not so much money as to create massive numbers of new, frivolous lawsuits.

The Ganske bill, on the other hand, allows for unlimited punitive and economic damages. This will be a tremendous enticement for frivolous lawsuits. Thus, way too much of the precious limited money available for patient health care will be chewed up in the litigation of these lawsuits, not for health care.

The bill of the gentleman from Iowa (Mr. GANSKE) also makes an effort, although an inadequate effort, to close off lawsuits against businesses which had absolutely nothing to do with the HMO's unlawful act. No business in its right mind will offer insurance or any kind of health care benefits to its employees if they can be sued for something they did not do.

If we want a legitimate Patients' Bill of Rights that actually wants a chance to become law this year and help these people we keep talking about, I strongly urge my colleagues to vote for the Norwood amendment.

Mr. NORWOOD. Mr. Chairman, it is a pleasure to yield to the gentleman from Ohio (Mr. BOEHNER), the chairman of the Committee on Education and the Workforce.

Mr. BOEHNER. Mr. Chairman, let me thank the gentleman for yielding me time, and let me say that all of us, I think, owe the gentleman from Georgia (Mr. NORWOOD) a great big thank-you. The gentleman has been at this for 6½ years as a Member of Congress.

I know when I went to his district in 1994 and campaigned with him, we went around his district, we spent 16 hours in a bus going to about 16 small towns in eastern Georgia. Those constituents in that district wanted a Patients' Bill of Rights.

The gentleman came up here, and we all know, every Member of Congress knows, there is nobody in this body who has worked harder, nobody who has put more heart and soul into trying to find the right language that will be signed into law than the gentleman from Georgia (Mr. NORWOOD), and we owe him a great big thanks.

Everybody thinks there is some big fight here, that there is some huge difference. Let us put it all back in perspective.

The bill we have here is an identical bill. We have one bill. The only big argument is over how much more liability we are going to impose on insurers and on employers.

The amendment offered by the gentleman from Georgia basically says that we are going to expand remedies and we are going to expand liability from where we are today, and we are going to give people easier access to courts. Our friends on the other side have an even greater expansion of liability in State and Federal courts, and what their language will do is drive employers out of the system, will drive up costs for employers and their employees. It will damage the foundation of our health insurance system today, which is employer-provided coverage.

What we are trying to do here is to find some common ground, and I think the gentleman from Georgia (Mr. NORWOOD), working with the President, has found common ground that will give patients in America greater access to the courts, greater remedies, bringing greater accountability. Not as much as we have on the other side, but our bill will not drive employers out of the system; it will not drive up costs. It is a reasonable compromise that the American people expect us to deliver for them.

Mr. ANDREWS. Mr. Chairman, it is my privilege to yield 2 minutes to the gentleman from Iowa (Mr. GANSKE), the principal voice for patients around America.

Mr. GANSKE. Mr. Chairman, I have here a ''Dear Colleague'' that was sent out by the gentleman from Georgia on August 1. It says, ''An explanation of how ERISA preemption works.'' It says, ''Under H.R. 2563,'' that is the base bill, the Ganske-Dingell bill, ''if an insurer injures you by denying or delaying medically necessary care, you can go to State court under common law to hold the insurer accountable.'' That has been a fundamental part of the bill.

So it surprised me greatly when I read on page 20 of the Norwood amendment these words: ''A civil action brought in any State court under section'' such and such ''against any party other than the employer plan, plan's sponsor or any other entity, i.e., dedicated decision-maker, arising from a medically reviewable determination may not be removed from any district court.''

What this basically means is that all of those groups can go into Federal, and that gets to then this interesting part of the Norwood bill. I mean, this could be interpreted as unconstitutional under Pegram v. Hedrick.

But then, at the end, we have a nonseverability clause, so that the entire enforcement section becomes inoperative if one section in the Norwood amendment is unconstitutional.

Mr. Chairman, I am just amazed at this. I know the gentleman from Georgia in the past has fought against putting nonseverability clauses in.

Mr. DINGELL. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to the gentleman from Michigan.

Mr. DINGELL. Mr. Chairman, all of that dies, but the preemption clause remains, and, as a result of this, the subscriber to the health care plan is left totally naked and devoid of any protection or any rights to enforce his interests in his policy.

Mr. NORWOOD. Mr. Chairman, I am pleased to yield 2 minutes to the gentleman from Ohio (Mr. PORTMAN).

Mr. PORTMAN. Mr. Chairman, I thank the gentleman from Georgia.

I just want to make the point that we just heard from the other side that somehow cases that are in State court would be removed to Federal district court. That would not happen under the Norwood amendment. It would be in State court with a Federal cause of action.

So I do not know what the point of that last statement was, but we are in State court, and that is a change. That is a change that the gentleman from Georgia (Mr. NORWOOD) brought to this debate.

I am a strong supporter of the Norwood amendment and I am also a strong supporter of the underlying bill.

I want to back up for a second and talk about why we are here. Eight years ago when I got elected to Congress, we were talking about the Patients' Bill of Rights, and it was about access to emergency room care, it was about access to OB–GYNs, it was about access to specialists, it was about access to clinical trials. All of this is in

this underlying legislation. This is the Patients' Bill of Rights we have been talking about for all of the 8 years I have been here.

But while this bill provides all of these patient rights, it also provides the single most important protection of all, and that is health care insurance coverage. It provides the right balance, yes, making HMOs and other insurance companies accountable; yes, providing access to the courts when one is aggrieved; but not raising the cost of health care insurance to the point that we is risking health care coverage for literally millions of Americans. That is the most fundamental protection of all. It is the right balance.

It is easy around this place to criticize. It is easy to be partisan, and we have heard some of that today on the floor. We have even heard some allegations of bad motives. We have even heard some allegations of corruption earlier on the floor. That is easy. What is harder is to get something done for the American people.

The American patient has waited too long. I commend the gentleman from Georgia (Mr. NORWOOD) for working hard on this issue not only for all of the time he has been in Congress, but over the last month, for working hard to find a bill that this President can sign and that provides the fundamental patients' rights that we have talked about and that provides the fundamental accountability for HMOs, and that delivers for the American people.

That is what this place is all about. That is the heavy lifting. I commend the gentleman from Georgia (Mr. NORWOOD).

Mr. ANDREWS. Mr. Chairman, I yield 2 minutes to the gentleman from Arkansas (Mr. BERRY), one of the leaders throughout this effort, a real expert on this matter.

Mr. BERRY. Mr. Chairman, I thank the gentleman from New Jersey, and I thank him for his leadership, along with many others that have worked hard on this issue. The gentleman from Iowa (Mr. GANSKE) has worked tirelessly and continues to work tirelessly in the interests of patients, particularly children.

It has been an interesting day. We have heard a lot of rhetoric on this floor. I have been almost amused. I say ''almost.'' This would be funny, it would be amusing if it was not such serious business. I have heard my colleagues on this side of the aisle stand in the well and talk about how our bill allows us to sue like they are proud of it. But this bill over here is a terrible thing; it lets you sue also.

Like I say, if it was not for the serious nature of this, it would be funny.

Meryl Haggart, a great country singer, has this song that he sings, made probably back in the 1980s, called Rainbow Stew. It says, ''When a President goes through the White House door and does what he says he will do, we will all be drinking that free bubble-up and eating that rainbow stew.''

This is the biggest batch of rainbow stew I have ever seen. That is what it is, folks. It is rainbow stew. That is what your constituents are going to get is rainbow stew.

I carry this buckeye in my pocket. It is a worthless little old thing. Folklore in Arkansas says if you carry one, it will bring you good luck and keep rheumatism away if you rub it just right. You have got to know how to rub it. That is what this is going to be worth to the American people.

Now, we have heard over and over that the real important thing about this is, it will be signed into law. If this ever gets signed into law, I will come to this floor, ask for unanimous consent, and stand on my head and stack BBs. And I am not in too good a shape. I think it would be very difficult.

I urge this body not to do something so foolish as to vote for this amendment.

Mr. NORWOOD. Mr. Chairman, I yield 1 minute to the gentleman from Texas (Mr. CULBERSON), a new Member of Congress who, I think, is a great addition to this Chamber.

Mr. CULBERSON. Mr. Chairman, I rise in very strong support of the Norwood amendment, because I am completely committed to protecting the 10th amendment right of the States to enact a Patients' Bill of Rights.

I came here on January 3 after serving 14 years in the Texas house. I am a coauthor of the Texas patients' bill of rights. I served longer under Governor Bush than any other governor. I helped carry all of his tort reforms in 1995. I helped pass this patients' bill of rights in Texas in 1997. So I know firsthand that this legislation the gentleman has drafted does not preempt the Texas patients' bill of rights, as has been stated. This bill protects the rights of States to regulate health care and to pass medical malpractice laws.

Mr. Chairman, I know that George W. Bush is a man of honor, integrity, and a man of his word; and he and the gentleman from Georgia (Mr. NORWOOD) have both given us their word that if there is any doubt that this bill would in any way preempt or restrict the rights of the States to regulate health care or protect patients' rights, they will fix it in conference. I believe the language they have now protects the rights of States.

I strongly support the amendment, and I urge Members who believe in the rights of States to protect the rights of patients at the State level to support this legislation.

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Mr. ANDREWS. Mr. Chairman, I yield 2½ minutes to the gentleman from Michigan (Mr. DINGELL), a giant in this institution, the dean of the House of Representatives and our great friend.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Chairman, I think it is time for us to look at this as what it is. I am told by my good friend on the other side that the problem here is lawsuits. I am sure they have trouble with that.

My problem is without some mechanism for the American citizen to think his rights are being properly protected in the courts of law, there is no sustainable right for that American citizen.

I had a good friend who called me up not long back. He is a doctor of medicine, very much respected. He had been serving as an appeals officer for an HMO since he retired. He said, DINGELL, you do not know it but they just fired me. I said, Doc, tell me why they did it. He said, They said I was making medical decisions instead of insurance decisions.

That is the issue here before us. We want to see to it that we still have medical decisions being made in favor of, and on behalf of, the patients. This is to see to it that the HMOs are treated the same as anybody else, not given preferential and reverential treatment.

That is what the Norwood amendment does. It shelters them against litigation. Worse than that it preempts State law; and in the process it jiggers the rules of evidence, the weight of the proceedings, the manner of proceedings, so that the hand of the Government is weighing heavily on the scales of justice against the citizen who has lost a leg or a wife or a husband or who has been injured by HMOs engaging in the practice of medicine.

If an American citizen cannot go to court to get relief and help under those situations, the value of his citizenship has been shrunk, and it will be shrunk by the Norwood amendment if it is adopted. Just remember what I stated about my friend who was fired for making medical decisions instead of insurance decisions.

Now, it does preempt the laws of the States now in existence; and it weighs the new proceedings against the person who wishes to complain to his government about having been wronged by an HMO. I have here in my hands a letter which I will insert in the RECORD at the appropriate time from the insurance commissioner from the State of Michigan, a good Republican official, who complains that the law of the State of Michigan is being usurped by the amendment offered by my good friend from Georgia. Protect my citizens, if you will not protect your own, against that kind of outrage.

OFFICE OF FINANCIAL AND
INSURANCE SERVICES,
Lansing, MI, August 2, 2001.

MICHIGAN CONGRESSIONAL DELEGATION,
House of Representatives, Washington, DC.

DEAR REPRESENTATIVES: I am contacting you again with regard to an amendment that is being proposed to the patients' bill of rights legislation. It has come to our attention that the Norwood amendment contains a provision that would preempt all State internal and external review laws. States would not be allowed to certify and retain these laws. The internal and external review process would be federalized.

I oppose the portion of the Norwood amendment that would preempt the Michigan Office of Financial and Insurance Services' ability to implement, oversee and enforce Michigan's statutory internal and external grievance procedures. Michigan was one of the first states to implement both an internal and external grievance procedure when it enacted its patient's bill of rights in 1996. Then again in 2000, the Michigan Legislature, with Governor Engler's support, enacted the Patient's Right to Independent Review Act (PRIRA–2000 PA 251) that provided sweeping changes to the external review procedure and shortened (considerably) the time frames for the internal review procedures. PRIRA took effect October 1, 2000.

I am asking for your help in resolving this preemption issue as the process moves forward. The Senate bill allows states to certify state laws and therefore retain their internal/external reviews, so this issue will be a point of negotiation in conference. It would be very helpful if enough Members objected to this provision in the Norwood amendment so that it is highlighted for those conference negotiations. If States are not allowed to retain jurisdiction over the internal and external review process then their ability to oversee other protections will be severely limited.

Very truly yours,

FRANK M. FITZGERALD,

Commissioner.

Mr. NORWOOD. Mr. Chairman, I yield myself such time as I may consume.

The CHAIRMAN. The gentleman from Georgia has 7 minutes.

Mr. NORWOOD. Mr. Chairman, this is not the ideal process I would have designed for this debate today. I am disappointed that some of my colleagues have allowed their passionate feelings about process to lead them into making dubious statements about substance, because this debate most assuredly should be about substance.

I would like to remind my colleagues of what my amendment provides for injured patients. A patient who is injured when an insurer makes a negligent denial of claim for benefits will have the opportunity to hold that insurer accountable in State court. The patient will have access to the State courts that we have together supported for years. The patient will hold the insurer liable under the same State rules and procedures that a doctor will be held accountable under. Is not this what we have been fighting for all these years?

My amendment includes those protections to prevent frivolous lawsuits that we have all fought to include in a bill. All of us. My amendment protects employers by allowing them to choose a designated decision-maker, so very important to all of us.

My amendment requires patients exhaust all administrative remedies. My amendment also includes a rebuttable presumption in favor of the plan if the reviewer rose in favor of the plan. While I know my friends have raised concerns about this provision, I continue to raise just one simple question: If an expert reviewer says an insurer was right in denying care, how was the insurer negligent in denying care? Should not they have some extra consideration?

My amendment includes limitations on damages. There is a $1.5 million cap on noneconomic damages. There is a cap on punitive damages of $1.5 million. That is only available when an insurer ignores an external reviewer. I believe personally in limitation of damages. Some of my colleagues do not, obviously. This is a legitimate area for debate, is it not?

Mr. Chairman, these issues I have raised are issues we should be debating. I am sorry that the debate has deteriorated some. I am disappointed that they feel that they have not been given adequate time for a debate. I will understand if they feel they cannot support my amendment solely because of process, because they have heard me complain before of similar things.

But before Members cast this vote against this bill, I ask them to consider what the amendment actually does; and more importantly, I want Members to support who supports this bill.

The President has committed to signing our bill with this amendment. I have been working for 5 years to get a bill signed into law, not just pass another bill. Like it or not, we have to work with this President who has to sign this bill.

I think my colleagues are deluding themselves, maybe, if they think we can force a bill down this President's throat. It is simply not going to happen with this honorable man from Texas. So I accept the President's offer to bridge the gap.

I know this is not the final bill, and so do the Members. I know there are words that need to be changed. I think my colleagues are missing the boat by treating every interpretation of a problem in my amendment, real or imagined, as a life-or-death decision.

Instead, we should be looking at the underlying offer and asking ourselves, is this an offer that accomplishes what we set out to do in creating a real remedy for patients?

Mr. Chairman, the answer to that question is yes. I encourage my colleagues, all my colleagues, to join me in accepting the President's offer of a compromise to go into conference. I would encourage my colleagues who will vote no today to set aside their feelings and ask themselves, what are they holding out for? What is it that they need to say yes to, once and for all changing the law of this great Nation to protect patients?

Mr. Chairman, I have found the answer, I believe. The working answer is in this amendment and in a conference. I would encourage my colleagues to join me in supporting this amendment. I am saddened deeply that it will not be bipartisan; and I know it will not, because I believe now and I have believed for years the true answer to this is a bipartisan solution.

I want to take a minute of personal privilege to thank all the Members. Many Members on both sides of the aisle have worked as hard as I have. I know who they are. I have worked as hard against my friend, the gentleman from Kentucky (Mr. FLETCHER), as anybody I know; but by golly, he has worked hard in his own way to protect patients, too.

Nobody I know has been around this issue consistently and constantly and every time I turn around more than my friend, the gentleman from Arizona (Mr. SHADEGG). He has added tremendously to this debate in many ways, which I do not have time to go over right now.

I want to say to all of my Democratic colleagues, I believe them very much when they say they want a patient protections bill. I believe that our Members do, too. I know how hard they have worked. I know who they are, too. I have had a few hours with them to try to work this out.

I just have to point out to all the Members, I want Members to know who Bridget Taylor is, a lady that I have the greatest respect and admiration for who has worked her little heart out for the benefit of patients of this Nation.

I want to say to my staff, I thank them. I know what I have done to them. My friend, Rodney Whitlock, has been with me 7 years; and I do not know many people who have taken a worse beating on my behalf than Rodney Whitlock in the last 2 weeks. I thank him.

And to my friend, the gentleman from Michigan (Mr. DINGELL), he knows I love him and respect him, and I know where he wants to go. He knows where I want to go. It has been a great honor working with the gentleman from Michigan. I appreciate his efforts on behalf of patients, too.

Lastly, I want to say to my friend, and I do mean that, to the gentleman from Iowa (Mr. GANSKE), I do not know anybody, including me, that has worked as hard as the gentleman has. I admire the gentleman so. I know he is trying to do the right things for his patients. God knows, there is nobody more persistent and tough and stubborn and willing to fight and stand up, and I have admired the gentleman so, because he has taken some tough hits. I know the people of Iowa need to be grateful to have you as their Representative in Congress.

Lastly, I want to say to all of the Members about the President of the United States, I do not make any bones about it, I love this man. I have gotten to know him. I have the greatest respect in the world for him. Whatever Members may think of him, I promise them, the President and his staff have worked me good for the last 2 weeks. What they have been trying to do is to get a patients' protection bill out that they can agree with.

I thank them for their efforts and thank all of the Members. I hope that at some point tonight we will have a bipartisan vote.

Mr. ANDREWS. Mr. Chairman, I yield myself the balance of my time.

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Mr. Chairman, let me begin by expressing my appreciation to my good friend, the gentleman from Michigan (Mr. DINGELL), whom I admire so much; to the gentleman from Iowa (Mr. GANSKE); and to all those involved.

The vote we are about to take is not about the good intentions of good and decent people, because there are many in this debate. It is about making a good choice for the people of our country, the people who are sitting in a hospital waiting-room tonight with their stomachs and their hearts in their throats, not just because they are worried about whether their loved one is going to recover, but whether they are going to have a hassle over who pays the bill. That is who we have to think about here tonight.

I respect those who are here tonight to try to help the President. I am here to try to help the patients of the United States of America here tonight.

To understand why I oppose this flawed amendment, Members need to understand the following situation. A person goes to her primary care provider. The primary care provider says, You really ought to see a specialist. She does not get the right to see the specialist because the HMO says no.

Because of the time delay, she develops a malignant tumor. She is in the hospital. She dies as a result of the malignant tumor. But before she dies, the wrong medications are administered to her wrongly by an employee of the hospital. Her estate sues the hospital and sues the HMO, not because they want to recover a lot of money, but because they have been wronged.

The way I read this bill, there is one word that denies that family's claim. Because despite whatever good intentions there might be, the law is about words, not good intentions. The words in this bill say that the actions of the HMO have to be the proximate cause of the injury.

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And a good lawyer, and, boy, the HMOs have really good lawyers, is going to figure out in a heartbeat how to beat that case. Because he or she is going to say the death here was not ''the'' proximate cause by the HMO, it was ''a'' proximate cause. So the claim gets tossed out.

This is not just about words, it is about values. If we want to hold the HMOs of this country accountable, this is the vote. There will not be another one. I do not think so. If my colleagues want to hold them accountable, they should come to floor, take out their card, and vote for the patients of this country. Vote ''no'' on the Norwood amendment.

Mr. WEXLER. Mr. Chairman, I would like to state for the record my enthusiastic support for the Dingell-Ganske Bi-Partisan Patients' Bill of Rights (H.R. 2563) and my opposition to the Norwood amendment. The Dingell-Ganske is the only true patient protection bill in Congress. H.R. 2563 allows patients to sue an HMO in state courts when they are denied care. Further, the bill allows patients to sue in federal court for breach of contract.

H.R. 2563 would return medical decisionmaking to patients and health care professionals. Americans would have greater access to specialists, including pediatric specialists for children and gynecologists for women. Coverage for emergency room care would be available, as well as the right to talk freely with doctors and nurses about every medical option. The Patients' Bill of Rights would end financial incentives for doctors and nurses to limit the care they provide. It would also provide an appeals process and real legal accountability for the decisions made by insurance companies.

Opponents of this bill claim that the Dingell-Ganske Patients' Bill of Rights would unnecessarily expose employers to lawsuits. In fact, the newly filed Dingell-Ganske bill includes amendments adopted in the Senate which shield employers from liability if they are not directly involved in the decisionmaking process.

In light of the passage of the McCain, Kennedy, Edwards Bipartisan Patients' Bill of Rights in the Senate, the Republican leadership has drafted a weak amendment that purports to protect patients' rights while at the same time protecting the insurance industry. At the last minute, the President, the Republican leadership and Congressman Norwood crafted an amendment that basically negates the Dingell-Ganske bill. While the Norwood Amendment claims to allow lawsuits to be filed in state courts, such suits would be limited by federal law. Further, the Norwood amendment allows employers to unilaterally remove an action from state to federal courts. Federal courts are the wrong venue for bringing medical suits. Federal courts are backlogged with cases that would take priority over civil actions. Further, federal courts do not have experience with medical suits because they are typically brought before state courts.

Additionally, the Norwood amendment unreasonably caps non-economic damages. Those without substantial income—the elderly, children and homemakers would suffer the most under these limited damage provisions. The Amendment also caps punitive damages and heightens the bar required to obtain compensation by asking juries to meet the ''clear and convincing'' standard prior to awarding damages. In short, the Amendment creates legal hurdles that make it almost impossible for a patient who is being denied care to get help from the courts.

All concerns over the Bipartisan Patient Protection bill have been resolved in the Senate and have been adopted in the newly drafted Dingell-Ganske. There is no reason to oppose this bill, unless you are trying to appease the insurance companies.

Ms. MILLENDER-McDONALD. Mr. Chairman, I rise in support of the base bill, Dingell-Norwood-Ganske-Berry. However, I am concerned about provisions in the Norwood amendment, if adopted, that will have a deleterious impact on women.

H.R. 2563, in its original form, provides protections for women and mothers and provides them with direct access to a physician specializing in obstetrics or gynecology, without them having to obtain prior authorization or referral from their primary physicians. The base bill requires that plans permit parents to designate a pediatrician as their child's primary provider. My district constituents will derive substantial benefits from this provision. Furthermore, the base bill provides vital protection regarding medical and surgical benefits for women afflicted with cancer, including coverage that a doctor deems medically necessary.

Mr. Speaker, it is paramount for us to pass a bill that establishes both internal and external appeals processes, and which allows women a mechanism to appeal a denial of a benefit claim to services and/or treatment that a doctor feels is necessary. Today I stand and champion the needs of all Americans, but particularly for women. I applaud the authors of the Dingell-Ganske-Berry bill. Their legislation is a beacon of good policy and intentions. On the other hand, the negotiated agreement, crafted under the cloak of secrecy and darkness, must not be tolerated nor condoned. I implore my colleagues to support the base bill, support women's needs contained within it, and support Americans who want and need a true patients bill of rights.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Chairman, opponents of the Bipartisan Patients' Bill of Rights contend that allowing the public to sue their HMOs will lead to a litigation explosion, a rise in health care costs, and insurance companies going bankrupt. Regardless of the fact that none of these theories have been proven, and that the facts actually show the opposite to be true, they are inundating the public with this misleading rhetoric. Well, those who live in glass houses should not throw stones. The managed care industry does not hesitate to sue when it protects its bottom line, regardless of the effect it has on patients.

Mr. Chairman, we must pass a Patients' Bill of Rights that no longer allows HMOs to maintain their privileged immunity from being held legally responsible to their patients. Though this is what we should do, many of my colleagues are willing to keep medical decisions in the hands of unqualified HMOs and support the Norwood amendment.

The amendment provides for a one-sided preemption of state damage caps. For states with no damage caps, the damage caps in this amendment would apply. States that currently do not cap damages would be forced to accept the damage limitations provided in this bill. Mr. Chairman, a $500,000 cap to cover damages for pain and suffering is not enough. Placing a cap on punitive damages erodes the deterrent effect of punitive awards.

Mr. Chairman, I would like to conclude with an example that may provide my colleagues with a clearer picture of what the Norwood amendment does to patients who depend on their insurance companies to provide for them.

Consider the woman with breast cancer. Her HMO denies her a mammogram, which could have detected it. The undetected cancer worsens. When it is finally diagnosed, it is beyond treatment. The woman dies. Her family brings a lawsuit against the HMO for failure to provide the mammogram that could have identified her condition and led to life saving treatment. Even if the jury finds fault with the HMO, $500,000 will not bring that woman back. $500,000 is not enough for pain and suffering. $500,000 is a slap on the wrist for an HMO that prevented a woman from receiving a mammogram that may have detected breast cancer, and possibly saved her life.

Now, I ask my colleagues to imagine that this woman was their mother, their wife, their

daughter. Would $500,000 be enough to raise your kids? Would $500,000 be enough to put your kids through college? Would $500,000 be enough to explain where their mother is? How then would they feel about the Norwood amendment—the amendment that stacks the deck against patients, the amendment that could possibly stack the deck against one of their loved ones?

Mr. OWENS. Mr. Chairman, I rise in opposition to the Norwood amendment to H.R. 2563, the Bipartisan Patient Protection Act, aka, the Patients' Bill of Rights.

The deception being debated here today is quite reminiscent of Orwell's novel when each day citizens wake up to a new reality. Yesterday, we left the Hill and Mr. Norwood was one of the leading proponents of a significant and fair Patient's Bill of Rights that was truly bipartisan. We arrived today and the Patients' Bill of Rights has been transformed into a HMO Bill of Rights, stripping both patients and states of the right to hold these ''sacred cows'' accountable. The extent to which the American people are being counted upon to ignore the details and simply ''don't worry, be happy'' that something was done is shameful and frightening.

A system of checks and balances is only fair and just. Why should the patient and their family members be left without recourse in the event of a tragic error simply because they belong to an HMO. This is a government of, by, and for the people, not HMO's. Our responsibility is to ensure a patient's right to sue health plans for injuries sustained as a result of a delay or denial of medical care. If anyone deserves a privileged status when involved in or affected by medical decisions it should be the potential victim.

A patient's right to recourse is an important check and balance in a system that must balance profit margins with patient needs. To take such an important protection away from American citizens is wrong. To further limit a state's right to protect its citizens from self serving decisions made by HMO's may be unconstitutional. To abandon our commitment to a meaningful Patient's Bill of Rights for political expedience is unconscionable. Mr. NORWOOD conceded too much. The Ganske/Dingell Bill offers us a chance to pass a true bipartisan Patient's Bill of Rights that is fair and just.

Mr. Chairman, to preserve states' rights and consumer rights; and to block one more path toward the corporate takeover of America, I urge my colleagues to defeat this poison amendment, and pass a fair Patient's Bill of Rights.

Mrs. CHRISTENSEN. Mr. Chairman, I rise in opposition to the Bush/Norwood amendment and I urge my colleagues to oppose its passage.

I agree with the American Medical Association, which oppose the Norwood amendment for four very good reasons.

First, the Norwood amendment overturns the good work that states like Texas and Georgia have done in protecting patients. It reverses developing case law that allows patients to hold plans accountable when they make decisions that harm them.

Second, the Norwood amendment takes away states power to set the standards by which HMOs can be punished with punitive damages creating a one-way preemption of states rights in favor HMOs.

Third, it gives HMOs an unfair advantage by raising the bar making it harder for patients to make their case in court.

Finally, and most troubling, the Norwood amendment provides patients protections on the one hand but does not allow them to enforce those same protections in court.

Mr. Chairman, the Norwood amendment and all of the amendments offered today, are nothing more than poison pills designed to kill the meaningful Ganske/Dingell patient protection bill by forcing a conference with the Senate.

I urge my colleagues to oppose the Norwood amendment, which is nothing more than a gift to the HMO industry. The American people want us to give them a real Patients' Bill of Rights with real enforcement provisions and real protections.

Mr. McGOVERN. Mr. Chairman, I rise today to urge this House vote against the Norwood-Bush amendment for Ganske-Dingell.

Norwood-Bush is not real reform. President Bush doesn't want to sign any meaningful patient protection legislation. As Governor, he never signed any Texas patient protection law, and now he is attempting to use this Congress to kill real patient protections.

For five years, the Republicans ignored patients by forcing through hollow patient protection bills that only benefit insurance companies. Today we have an opportunity to finally put patients ahead of bureaucrats and beancounters.

President Bush wants the House to pass a bill just different enough that the Senate cannot support it. The House Republican leadership can then kill the bill in conference.

Patients, their families and their physicians deserve much better.

The Norwood-Bush proposal is about bad politics, not good policy.

Let's get past the politics. Let's do this right. Pass the Ganske-Dingell bill.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Georgia (Mr. NORWOOD).

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. ANDREWS. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 218, noes 213, not voting 3, as follows:

[Roll No. 329]

AYES—218

Aderholt	Burton	Davis, Tom
Akin	Buyer	Deal
Armey	Callahan	DeLay
Bachus	Calvert	DeMint
Baker	Camp	Diaz-Balart
Ballenger	Cannon	Doolittle
Barr	Cantor	Dreier
Bartlett	Capito	Duncan
Barton	Castle	Dunn
Bass	Chabot	Ehlers
Bereuter	Chambliss	Ehrlich
Biggert	Coble	Emerson
Bilirakis	Collins	English
Blunt	Combest	Everett
Boehlert	Cooksey	Ferguson
Boehner	Cox	Flake
Bonilla	Crane	Fletcher
Bono	Crenshaw	Foley
Brady (TX)	Cubin	Forbes
Brown (SC)	Culberson	Fossella
Bryant	Cunningham	Frelinghuysen
Burr	Davis, Jo Ann	Gallegly
Gekas	Latham	Ryun (KS)
Gibbons	LaTourette	Saxton
Gilchrest	Lewis (CA)	Scarborough
Gillmor	Lewis (KY)	Schaffer
Gilman	Linder	Schrock
Goode	LoBiondo	Sensenbrenner
Goodlatte	Lucas (KY)	Sessions
Goss	Lucas (OK)	Shadegg
Graham	Manzullo	Shaw
Granger	McCrery	Shays
Graves	McHugh	Sherwood
Green (WI)	McInnis	Shimkus
Greenwood	McKeon	Shuster
Grucci	Mica	Simmons
Gutknecht	Miller (FL)	Simpson
Hansen	Miller, Gary	Skeen
Hart	Moran (KS)	Smith (MI)
Hastert	Myrick	Smith (TX)
Hastings (WA)	Nethercutt	Souder
Hayes	Ney	Stearns
Hayworth	Northup	Stump
Hefley	Norwood	Sununu
Herger	Nussle	Sweeney
Hilleary	Osborne	Tancredo
Hobson	Ose	Tauzin
Hoekstra	Otter	Taylor (NC)
Horn	Oxley	Terry
Hostettler	Pence	Thomas
Houghton	Peterson (MN)	Thornberry
Hulshof	Peterson (PA)	Thune
Hunter	Petri	Tiahrt
Hutchinson	Pickering	Tiberi
Hyde	Pitts	Toomey
Isakson	Platts	Traficant
Issa	Pombo	Upton
Istook	Portman	Vitter
Jenkins	Pryce (OH)	Walden
Johnson (CT)	Putnam	Walsh
Johnson, Sam	Quinn	Wamp
Jones (NC)	Radanovich	Watkins (OK)
Keller	Ramstad	Watts (OK)
Kelly	Regula	Weldon (FL)
Kennedy (MN)	Rehberg	Weldon (PA)
Kerns	Reynolds	Weller
King (NY)	Riley	Whitfield
Kingston	Rogers (KY)	Wicker
Kirk	Rogers (MI)	Wilson
Knollenberg	Rohrabacher	Wolf
Kolbe	Ros-Lehtinen	Young (AK)
LaHood	Royce	Young (FL)
Largent	Ryan (WI)	

NOES—213

Abercrombie	DeGette	John
Ackerman	Delahunt	Johnson (IL)
Allen	DeLauro	Johnson, E. B.
Andrews	Deutsch	Jones (OH)
Baca	Dicks	Kanjorski
Baird	Dingell	Kaptur
Baldacci	Doggett	Kennedy (RI)
Baldwin	Dooley	Kildee
Barcia	Doyle	Kilpatrick
Barrett	Edwards	Kind (WI)
Becerra	Engel	Kleczka
Bentsen	Eshoo	Kucinich
Berkley	Etheridge	LaFalce
Berman	Evans	Lampson
Berry	Farr	Langevin
Bishop	Fattah	Lantos
Blagojevich	Filner	Larsen (WA)
Blumenauer	Ford	Larson (CT)
Bonior	Frank	Leach
Borski	Frost	Lee
Boswell	Ganske	Levin
Boucher	Gephardt	Lewis (GA)
Boyd	Gonzalez	Lofgren
Brady (PA)	Gordon	Lowey
Brown (FL)	Green (TX)	Luther
Brown (OH)	Gutierrez	Maloney (CT)
Capps	Hall (OH)	Maloney (NY)
Capuano	Hall (TX)	Markey
Cardin	Harman	Mascara
Carson (IN)	Hastings (FL)	Matheson
Carson (OK)	Hill	Matsui
Clay	Hilliard	McCarthy (MO)
Clayton	Hinchey	McCarthy (NY)
Clement	Hinojosa	McCollum
Clyburn	Hoeffel	McDermott
Condit	Holden	McGovern
Conyers	Holt	McIntyre
Costello	Honda	McKinney
Coyne	Hooley	McNulty
Cramer	Hoyer	Meehan
Crowley	Inslee	Meek (FL)
Cummings	Israel	Meeks (NY)
Davis (CA)	Jackson (IL)	Menendez
Davis (FL)	Jackson-Lee (TX)	Millender-McDonald
Davis (IL)	Jefferson	Miller, George
DeFazio		

Mink	Rodriguez	Stenholm
Mollohan	Roemer	Strickland
Moore	Ross	Stupak
Moran (VA)	Rothman	Tanner
Morella	Roukema	Tauscher
Murtha	Roybal-Allard	Taylor (MS)
Nadler	Rush	Thompson (CA)
Napolitano	Sabo	Thompson (MS)
Neal	Sanchez	Thurman
Oberstar	Sanders	Tierney
Obey	Sandlin	Towns
Olver	Sawyer	Turner
Ortiz	Schakowsky	Udall (CO)
Owens	Schiff	Udall (NM)
Pallone	Scott	Velazquez
Pascrell	Serrano	Visclosky
Pastor	Sherman	Waters
Payne	Shows	Watson (CA)
Pelosi	Skelton	Watt (NC)
Phelps	Slaughter	Waxman
Pomeroy	Smith (NJ)	Weiner
Price (NC)	Smith (WA)	Wexler
Rahall	Snyder	Woolsey
Rangel	Solis	Wu
Reyes	Spratt	Wynn
Rivers	Stark	

NOT VOTING—3

Lipinski	Paul	Spence

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Mr. ISTOOK changed his vote from ''no'' to ''aye.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

The CHAIRMAN. It is now in order to consider Amendment No. 3 printed in House Report 107–184.

AMENDMENT NO. 3 OFFERED BY MR. THOMAS

Mr. THOMAS. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 3 offered by Mr. THOMAS:

Add at the end the following new title (and amend the table of contents of the bill accordingly):

TITLE VIII—REFORMS RELATING TO HEALTH CARE LIABILITY CLAIMS

SEC. 801. TABLE OF CONTENTS OF TITLE.

The table of contents of this title is as follows:

SEC. 802. APPLICATION IN STATES.

The provisions of this title relating to any requirement or rule shall not apply with respect to a health care lawsuit brought under State law insofar as the applicable statutory law of that State with respect to such lawsuit specifies another policy with respect to such requirement or rule.

SEC. 803. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

Health care lawsuits shall be commenced no later than 2 years after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury for which the lawsuit was brought. In all cases, a health care lawsuit shall be filed no later than 5 years after the date of the injury. The time periods for filing health care lawsuits established in this section shall not apply in cases of malicious intent to injure. To the extent that chapter 171 of title 28, United States Code, relating to tort procedure, and, subject to section 802, State law (with respect to both procedural and substantive matters), establishes a longer period during which a health care lawsuit may be initiated than is authorized in this section, such chapter or law is superceded or preempted.

SEC. 804. COMPENSATING PATIENT INJURY; FAIR SHARE RULE.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, the full amount of a claimant's economic loss may be fully recovered, subject to section 809(d)(2), without limitation.

(b) ADDITIONAL NON-ECONOMIC DAMAGES.—Subject to section 809(d)(2), in any health care lawsuit, the amount of non-economic damages may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(c) NO DISCOUNT OF AWARD FOR NON-ECONOMIC DAMAGES.—In any health care lawsuit, an award for future non-economic damages shall not be discounted to present value. The jury shall not be informed of the maximum award for non-economic damages. An award for non-economic damages in excess of the amount specified in subsection (b) (or the amount provided under section 809(d)(2), if applicable) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future non-economic damages and the combined awards exceed the amount so specified, the future non-economic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for the party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

(e) ADDITIONAL HEALTH BENEFITS.—In any health care lawsuit, any party may introduce evidence of collateral source benefits. If any party elects to introduce such evidence, the opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of such opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit. This subsection shall apply to a health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder.

(f) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care lawsuit in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm; or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any such health care lawsuit on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages.

(3) LIMITATION ON PUNITIVE DAMAGES.—The total amount of punitive damages that may be awarded to a claimant for losses resulting from the injury which is the subject of such a health care lawsuit may not exceed the greater of—

(A) 2 times the amount of economic damages, or

(B) $250,000,

regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. Subject to section 802, this subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(g) LIMITATIONS ON APPLICABILITY OF THIS SECTION.—This section applies only to health care lawsuits. Furthermore only to the extent that—

(1) chapter 171 of title 28, United States Code, relating to tort procedure, permits the recovery of a greater amount of damages than authorized by this section, such chapter shall be superseded by this section; and

(2) only to the extent that either chapter 171 of title 28, United States Code, relating to tort procedure, or, subject to section 802, State law (with respect to procedural and substantive matters), prohibits the introduction of evidence regarding collateral source benefits or mandates or permits subrogation or a lien on an award of damages for the cost of providing collateral source benefits, such chapter or law is superseded or preempted by this section.

SEC. 805. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a period payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws in July 1990. This section applies to all actions which have not been first set for trial or retrial prior to the effective date of this title.

(b) LIMITATION ON APPLICABILITY OF THIS SECTION.—Only to the extent that chapter 171 of title 28, United States Code, relating to tort procedure, or, subject to section 802, State law (with respect to both procedural and substantive matters), reduces the applicability or scope of the regulation of periodic payment of future damages as authorized in this section, is such chapter or law preempted or superseded.

SEC. 806. NO PUNITIVE DAMAGES FOR HEALTH CARE PRODUCTS THAT COMPLY WITH FDA STANDARDS.

(a) GENERAL RULE.—In the case of any health care lawsuit, no punitive or exemplary damages may be awarded against the manufacturer of a medical product based on a claim that the medical product caused the claimant's harm if the medical product complies with FDA standards.

(b) EXCEPTION.—Subsection (a) shall not apply in any health care lawsuit in which—

(1) before or after the grant of FDA permission to market a medical product, a person knowingly misrepresents to or withholds from the FDA required information that is material and relevant to the performance of such medical product, if such misrepresentation or withholding of information is causally related to the harm which the claimant allegedly suffered; or

(2) a person makes an illegal payment to an official of FDA for the purpose of either securing or maintaining approval of such medical product.

SEC. 807. EFFECT ON OTHER LAWS.

This title does not affect the application of title XXI of the Public Health Service Act (relating to the national vaccine program). To the extent that this title is judged to be in conflict with such title XXI, then this title shall not apply to an action brought under such title. If any aspect of such a civil action is not governed by a Federal rule of law under such title, then this title or otherwise applicable law (as determined under this title) will apply to that aspect of the action.

SEC. 808. DEFINITIONS.

As used in this title:

(1) ALTERNATIVE DISPUTE RESOLUTION.—The term ''alternative dispute resolution'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal Court.

(2) AMOUNT RECOVERED BY CLAIMANTS.—The term ''amount recovered by claimants'' means the total amount of damages awarded to a party, after taking into account any reduction in damages required by this title or applicable law, and after deducting any disbursements or costs incurred in connection with prosecution or settlement of a claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose. Such term does not include any punitive or exemplary damages.

(3) CLAIMANT.—The term ''claimant'' means any person who asserts a health care liability claim or brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care lawsuit, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(4) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(5) COMPLIES WITH FDA STANDARDS.—The term ''complies with FDA standards'' means, in the case of any medical product, that such product is either—

(A) subject to pre-market approval or review by the Food and Drug Administration under section 505, 506, 510, 515 or 520 of the Federal Food, Drug, and Cosmetic Act (21 U.S. C. 355, 356, 360, 360e, 360j) or section 351 of the Public Health Service Act (42 U.S. C. 262) and such approval or review concerns the adequacy of the packaging or labeling of such medical product or the safety of the formulation or performance of any aspect of such medical product which a health care lawsuit claims caused the claimant's harm, and such medical product was marketed in conformity with the regulations under such sections, or

(B) generally recognized as safe and effective pursuant to conditions established by the FDA and applicable FDA regulations, including those related to packaging and labeling.

(6) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(7) ECONOMIC LOSS.—The term ''economic loss'' means reasonable amounts incurred for necessary health treatment and medical expenses, lost wages, replacement service losses, and other pecuniary expenditures due to personal injuries suffered as a result of injury.

(8) FDA.—The term ''FDA'' means the Food and Drug Administration.

(9) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any medical product, or any service provided by a health care provider or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(10) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services, or any civil action concerning the provision of health care goods or services brought in a State or Federal Court or pursuant to an alternative dispute resolution procedure, against a health care provider or the manufacturer, distributor, supplier, marketer, promoter or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person (whether or not pursuant to an alternative dispute resolution system, an action in State court, or an action in Federal court) concerning the provision of health care goods or services, if made against a health care provider or the manufacturer, distributor, supplier, marketer, promoter or seller of a medical product, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision or use of (or the failure to provide or use) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care goods or services or whose health care goods or services are required to be so licensed, registered, or certified, or which are exempted from such requirement by other statute or regulation.

(13) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a health care liability claim.

(14) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(15) MEDICAL PRODUCT.—The term ''medical product'' means a drug (as defined in section 201(g)(1) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device as defined in section 201(h) of such Act (21 U.S.C. 321(h)), including anycomponent or raw material used therein, but excluding health care services.

(16) NON-ECONOMIC LOSS.—The term ''non-economic loss'' means physical impairment, emotional distress, mental anguish, disfigurement, loss of enjoyment, loss of companionship, loss of services, loss of consortium, and any other non-pecuniary losses.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of a claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

(20) STATE LAW.—The term ''State law'' includes all constitutional provisions, statutes, laws, judicial decisions, rules, regulations, or other State action having the effect of law in any State.

SEC. 809. EFFECTIVE DATE; GENERAL PROVISIONS.

(a) IN GENERAL.—This title shall apply to any health care lawsuit brought in a Federal or State court, and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this Act, except that any health care lawsuit arising from an injury occurring before the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

(b) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, relating to tort claims procedure and, subject to section 802, preempt State law to the extent that State law differs from any provisions of law established by or under this title.

(c) PROTECTION OF STATES' RIGHTS.—Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) will be governed by otherwise applicable State or Federal law. Subject to subsection (d)(2) and section 802, this title does not preempt or supersede any law that imposes greater protections for health care providers, plans, and organizations from liability, loss, or damages that those provided by this title.

(d) RULE OF CONSTRUCTION.—No provision of this title shall be construed to preempt—

(1) the implementation of any State sponsored or private alternative dispute resolution program;

(2) pursuant to section 802, any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the total amount of economic, non-economic, or punitive damages that may be awarded in a health care lawsuit, whether or not such State statutory limit permits the recovery of a greater or lesser amount of such damages than is provided for under section 804; or

(3) any defense available to a party in a health care lawsuit under any other provision of Federal law.

The CHAIRMAN. Pursuant to House Resolution 219, the gentleman from California (Mr. THOMAS) and the gentleman from Michigan (Mr. CONYERS) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS.)

Mr. THOMAS. Mr. Chairman, I yield myself 3 minutes. Subsequent to that I yield the balance of my time to the gentleman from California (Mr. COX) and ask unanimous consent that he control the balance of the time.

The CHAIRMAN. Without objection, the gentleman from California (Mr. COX) will control the balance of the time.

There was no objection.

(Mr. THOMAS asked and was given permission to revise and extend his remarks.)

Mr. THOMAS. Mr. Chairman, the amendment that was just passed puts a limit on the amount that can be received in terms of damages. One side of the equation has been adjusted properly. Notwithstanding the fact you can seek damages, there is a limit.

This amendment proposes to create balance, put a limit on the other side of the equation. What you see here is a quote from a letter from the American College of Surgeons to the President of the United States on February 7. It says:

If the Congress seriously entertains caps on punitive and noneconomic damages—we have just done that—we believe it would be difficult if not impossible to explain why Federal policymakers did not at the same time address the liability exposure faced by physicians, hospitals and other health care practitioners.

It would be unfair, the College of Surgeons said, to enact a patients' bill of rights that caps damages for suits against health plans without capping damages for suits brought against physicians and other health care providers. This is exactly what this amendment does. It does not intrude on any State that has in place its own desired medical malpractice structure, but where there is none, this amendment will provide one unless and until the State passes its own and the State's prerogative would then prevail. It is simply an opportunity to provide a degree of uniformity where there is none today.

Mr. Chairman, it is my pleasure to include for the RECORD a letter, I might say a long overdue letter, from the American Medical Association.

It says, and I quote, on behalf of the American Medical Association, we would like to express our support for medical liability reform consistent with the general tort reform provisions included in the amendment to H.R. 2563 being offered by the gentleman from California (Mr. COX), myself, Chairman TAUZIN, Chairman BOEHNER and Chairman SENSENBRENNER.

The American Medical Association has gone on record in support of this medical malpractice amendment. Let us bring symmetry to this package. Let us put limits on plans. Let us put limits on physicians. Let us move forward in a way in which, as we go to conference, we will know for sure that at long last there is balance in the way in which assessment and the metering out is done where patients' health is concerned.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Illinois, August 2, 2001.

Hon. CHRIS COX,
U.S. House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE COX: On behalf of the American Medical Association (AMA) we would like to express our support for medical liability reform consistent with the general tort reform provisions included in the amendment to H.R. 2563 being offered by you and Representatives Bill Thomas, Billy Tauzin, John Boehner, and Jim Sensenbrenner.

AMA policy has long supported medical liability reform and we appreciate your efforts in this regard. As you know we have expressed concerns in the past about coupling such reforms with the Patients' Bill of Rights. As we enter conference it continues to be our hope that controversy surrounding this amendment will not interfere with the ultimate passage of meaningful patients' rights legislation.

This issue remains a high priority for the AMA and we stand ready to work with you on this or any other matter.

Respectfully,

ROBERT W. GILMORE, MD

Mr. CONYERS. Mr. Chairman, I yield myself such time as I may consume.

Ladies and gentlemen of the House, we are now reaching perhaps the worst amendment on medical malpractice that has ever been brought forward to the House of Representatives. I say that carefully because the one that the Republicans brought forward in 1995 was a real doozy, but this one goes further than that one. This caps doctors and hospitals. What makes it worse than 1995 is that it extends medical malpractice protection to insurance and HMO companies.

Secondly, it lowers punitive damage caps to only two times the economic damages, or $250,000, where the 1995 bill in its generosity limited it to three times economic damages, or $250,000.

Third, it has new limitations on accruing interest on noneconomic damages.

Finally, it applies limitations to private settlements as well as court cases.

So here in a system where each State has heretofore determined what the economic damages would be, what the noneconomic damages would be, what the punitive damages would be, here the majority party in this body has now determined that we are not only going to protect HMOs, we are going to cap suits against doctors and hospitals.

In a single stroke, the Thomas amendment, which is joined in by several chairmen on the other side as well, would place an arbitrary and capricious cap on the ability of the millions of persons harmed by medical negligence to recover in their own State courts. This amendment is even worse than the coverage in the Norwood amendment; and as I have said, this is the most severe and limiting malpractice amendment ever considered by the House.

If it were adopted, Congress would be saying to the American people, We don't care if you lose your ability to bear children; we don't care if you're forced to bear excruciating pain for the remainder of your life; we don't care if you're permanently disfigured or crippled, because under this amendment, a medical professional who fell asleep in the operating room or operated on the wrong patient would be completely insulated from punitive damages. The language goes so far as to cap the liability of a doctor, heaven forbid, who even rapes his patient. Do Members not know that punitive damages are the only way to deter such outrageous conduct?

The new statute of limitations takes no account of the fact that many injuries caused by malpractice or faulty drugs take years, sometimes decades, to manifest themselves. Under this proposal, a patient who is negligently inflicted with HIV-infected blood and develops AIDS 6 years later would be forever barred from filing a liability claim.

The so-called periodic payment provisions are nothing less than a Federal installment plan for HMOs. The bill allows insurance companies teetering on the verge of bankruptcy to delay and then completely avoid future financial obligations. Have you no shame? They would have no obligation to pay interest on amounts they owe their victims.

And guess what else happens under this sweetheart deal of an amendment? The drug companies, the producers of killer devices like the Dalkon Shield, the Cooper-7 IUD, high absorbency tampons linked to toxic shock syndrome and silicone gel implants, all would have completely avoided billions of dollars in damages had this bill been law.

Somewhere between 80 to 100,000 people die in this country each year from medical malpractice. It is the third leading cause of preventable deaths in America. If we pass this amendment, there is no question that the pain and suffering and deaths will increase. And this Congress will be to blame.

Therefore, I urge a ''no'' vote on the Thomas amendment.

Mr. Chairman, this ''poison pill'' amendment represents the most far reaching and dangerous malpractice provision ever considered by the Congress, and is even worse than previous malpractice limitations passed during the

''Contract with America.'' Unlike previous malpractice amendments taken up the Republican House, this would apply to limit HMO and insurance company liability. It would also supersede state laws to severely limit recoveries by harmed patients. The following is a more detailed description.

Scope and Preemption (Secs. 802,809)—the amendment preempts state law and the federal torts claims act with regard to any health care actions, even privately negotiated claims and those submitted to arbitration. This means the bill would limit the liability of physicians, drug companies, and hospitals. In addition, it would limit the liability of HMO's and insurance companies in a far more severe fashion that the Norwood amendment or the Fletcher bill.

Statute of limitations/repose (Sec. 803)—provides for a statute of limitations that prohibits victims from bringing any health care lawsuit more than two years after an injury is discovered. It also provides for a statute of repose that prohibits victims from bringing any health care lawsuit more than five years after the negligent conduct that caused the injury first occurred. The above time limitations for initiating a health care lawsuit will not apply in cases where there is a ''malicious'' intent to injure—an almost impossible standard to meet. Thus under the proposal, a patient who is negligently inflicted with HIV-inflected blood and develops AIDS 6 years later would be forever barred from filing a medical malpractice or product liability claim.

Cap on Non-economic Damages (Sec. 804(b), (c))—caps the award of non-economic damages in health care lawsuits at $250,000 regardless of the number of defendants involved. These caps are far more restrictive than the caps on non-economic damages proposed in the Norwood amendment of $1.5 million. Although harder to scientifically measure, non-economic damages compensate victims for real losses—such as loss of sight, disfigurement, inability to bear children, incontinence, inability to feed or bathe oneself, or loss of a limb—that are not accounted for in lost wages. Caps on non-economic damages would unfairly penalize those victims who suffer the most severe injury and are most in need of financial security. Non-economic damage caps have also been found to have a disproportionately negative impact on women, minorities, the poor, the young, and the unemployed; since they generally have lower wages, a greater proportion of their losses is non-economic. The bill also provides that an award for future non-economic damages will not be discounted to present value, which would appear to mean that there will be no adjustment made for inflation when non-economic damages are awarded. This restriction has never been proposed in any previous malpractice amendment.

Joint and Several Liability (804)(d))—provides that in any health care lawsuit concerning the provision of health care goods or services, each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. This provision eliminates the state doctrine of joint and several liability for non-economic damages, and raises the concern that instead of placing the burden of financial loss on the identifiable defendant, victims who prevail on a liability claim may not be able to recover all of their damages.

Collateral Source (804(e))—eliminates the collateral source rule by allowing defendants in medical malpractice cases to unilaterally introduce evidence of collateral source payments received or to be received by the claimant, such as health or disability insurance. In most states under the collateral source rule, a victim is able to obtain compensation for the full amount of damages incurred, and his or her health insurance provider is able to seek subrogation in respect of its own payments to the victim. This ensures that the true cost of damages lies with the wrongdoer while eliminating the possibility of double recovery by the victim. The Thomas amendment would turn this system on its head by allowing tortfeasors to introduce evidence of potential collateral payments owing from the insurer to the victim. This would have the effect of shifting costs from negligent health care providers at the expense of injured victims.

Limits on Punitive Damages (804(f))—caps punitive damage awards at the greater of $250,000 or two times economic damages and limits the state law standard for the award of punitive damages to intentional or ''consciously indifferent'' conduct; and allows for a bifurcated proceeding to determine issues relating to punitive damages. Again, the cap on punitive damages in the Thomas amendment is far worse than even the Norwood amendment which caps punitive damages at $1.5 million. It is also more severe than previously considered malpractice amendments. Punitive damages impose punishment for outrageous and deliberate misconduct and they deter others from engaging in similar behavior. Collectively, these restrictions on punitive damages are likely to completely eliminate not only the incentive for seeking punitive damages, but any realistic possibility of obtaining them. Permitting defendants to bifurcate proceedings concerning the award of punitive damages will lead to far more costly and time-consuming proceedings, again working to the disadvantage of injured victims.

Periodic Payments (805)—grants wrongdoers the option of paying damage awards in excess of $50,000 on an ''installment plan.'' This provision would apply not only to future economic damages realized over time, such as lost wages, but to non-economic losses, like the loss of a limb, that are realized all at once. Also, in contrast to many state law periodic payment provisions, the Thomas proposal does not seek to protect the victim from the risk of nonpayment resulting from future insolvency by the wrongdoer or to specify that future payments should be increased to account for inflation or to reflect changed circumstances.

Elimination of Punitive Damages for FDA approved health care products—completely bans punitive damages in the case of drugs or other devices that have been approved by the FDA or any other drug ''generally recognized as safe and effective'' pursuant to FDA-established conditions. Injuries from medical devices have an estimated cost of $26 billion annually. It is problematic to use compliance with the FDA as a basis for immunity from punitive damages when those regulations have proven inadequate to protect patients numerous times in the past. Government safety standards, at their best, establish only a minimum level of protection for the public. At their worst, they can become outdated, under-protective or under-enforced. Providing immunity from punitive damages to these manufacturers would eliminate the possibility of recovering these costs and would shift the burden to the injured patient. Banning punitive damages for FDA-approved products will also have a disproportionate impact on women and seniors, since they make up the largest class of victims of medical products.

The Thomas amendment also ignores a number of complex legal issues. For example, in the state law context, various damage caps have been held to violate state constitutional guarantees relating to equal protection, due process, and rights of trial by jury and access to the courts; and these very same concerns will surely be present at the Federal level. And by layering a system of Federal rules on top of a two-century old system of State common law, the Thomas amendment will inevitably lead to confusing conflicts, not only within the Federal and State courts, but between Federal and State courts.

Mr. Chairman, I reserve the balance of my time.

Mr. COX. Mr. Chairman, I yield such time as he may consume to the gentleman from Florida (Mr. SHAW).

(Mr. SHAW asked and was given permission to revise and extend his remarks.)

Mr. SHAW. Mr. Chairman, I rise in strong support of the Patients' Bill of Rights and this amendment to reform malpractice.

Mr. Chairman, in the last Congress I cosponsored the Bipartisan Consensus Managed Care Improvement Act, known as the Dingell-Norwood bill, after much serious consideration. I decided to support this reform legislation, in opposition to Republican leadership, in order to send a strong message to patients and the managed care industry about the importance of addressing managed care abuses. Notwithstanding my support for the Dingell-Norwood bill in 1999, I remained concerned that implementation of that bill could increase health insurance costs and expand liability to employers and health plans, and therefore voted for several less litigious substitutes last year. As a result, this year I am cosponsor of H.R. 2315, Patients' Bill of Rights Act of 2001, which was introduced by Representative Ernie Fletcher and endorsed by President George W. Bush.

Because of my concern that the new Ganske-Dingell bill could result in a tidal wave of medical malpractice lawsuits against health plans, HMOs—and, make no mistake about it—doctors, hospitals and other health care providers, I rise in strong support of the Thomas-Cox Medical Malpractice Reform Amendment.

Currently, even before the drastic expansion of medical malpractice lawsuits that would certainly result from passage of the new Ganske-Dingell bill, it was estimated that the direct and indirect costs of medical malpractice reform cost the Medicare program approximately $1.5 billion over a 10 year period. Why? Because the threat of lawsuits results in physicians practicing defensive medicine—for example, ordering extra tests or treatments that they might not otherwise do. This adds *indirectly* to Medicare costs at a time when the Medicare program, like the Social Security program, will be running a deficit in the near future as millions of baby boomers become eligible for Medicare.

Yet, we know from a 1996 study of Medicare heart attack victims that the additional tests and treatments did not help or harm these Medicare heart patients. Yet the defensive medicine test increased these heart attack patient's hospital and doctor's bills from five to nine percent. Medical malpractice premiums are also incorporated as *direct* Medicare costs that determine how much a doctor or hospital is paid for each Medicare patient they treat. Again, Medicare is currently paying every day for direct and indirect medical malpractice costs that do not improve the quality of health care that Medicare patients receive.

We have to remember that this is a *patient's* bill of rights, so why would we want to drive up a patient's hospital and doctor bills if the patient's recovery are not improved? Medicare savings that would result from these medical malpractice reforms—which, as I mentioned earlier, the CBO estimated to be $1.5 billion over 10 years—could be applied to a new Medicare prescription drug benefit or to improving Medicare's preventive health care benefits like breast, cervical or prostate cancer screening. Likewise, patients who have private health insurance would ultimately benefit from lower medical bills, which keep health insurance premiums down, helping to ensure that health insurance remains affordable for individuals and employers. In the absence of this Thomas-Cox Medical Malpractice Reform Amendment, the health care dollars that are diverted from providing patient care and into the legal system will explode. Will redirecting health care dollars into trial lawyers' pockets and the courts provide patients with any better care—which should be the true measure of a patients bill of rights? Research has shown that the threat of medical malpractice lawsuits will not improve patient care.

What I have concluded, as a Member committed to ensuring that managed care plans should be held liable for their decisions, is that Congress needs to:

First enact a bill which ensures that patients have a indisputable right to hold health plans and all health care providers legal accountable for quality health care.

Second, that the new limited right to sue created by Congress be balanced by pairing it with the medical malpractice reforms in the Thomas-Cox Medical Malpractice Reform Amendment—reforms that are similar to the reforms 20 states already have.

In closing, I support a strong Patients' Bill of Rights that is balanced by holding health care providers legally accountable with the reasonable limits on medical malpractice lawsuits contained in the Thomas-Cox Medical Malpractice Reform Amendment.

Mr. COX. Mr. Chairman, I yield myself 30 seconds for the purpose of correcting the record because the gentleman from Michigan has just stated several things that are factually in error.

First, he said that this amendment would apply to health plans, that it would provide relief from damages to health plans. It does not. It has no application to health plans or insurers. If it did, the American Medical Association would not endorse it.

Second, he said that it preempts State law. It preempts no State law. None.

Third, he said that intentional conduct such as a rape would somehow go scott free under this. That is flat wrong. Intentional conduct is excepted.

Lastly, he said that if a professional fell asleep or were negligent that he/she would not be responsible for punitive damages. That is simply false.

Mr. Chairman, I reserve the balance of my time.

Mr. CONYERS. Mr. Chairman, I yield myself 1 minute. I just want to ask the floor manager, the gentleman from California (Mr. COX), if I heard him correctly when he said that this measure before us preempts no State law.

I yield to him for a yes or no response.

Mr. COX. Mr. Chairman, that is correct. Section 802 specifically states that.

Mr. CONYERS. Mr. Chairman, I yield 2 minutes to the gentleman from Virginia (Mr. SCOTT), a member of the Committee on the Judiciary.

Mr. SCOTT. Mr. Chairman, I thank the gentleman for yielding time. It is ironic that when you have a bill entitled Patients' Bill of Rights, we are spending all of our time stripping the patients of those rights.

There are many issues in this amendment, about 10 different issues, we have got 20 minutes to explain them all which is about 2 minutes per issue as we strip our patients of their fundamental rights and traditional laws when they are victims of negligence.

Questions like the statute of limitations. When do you lose your right to sue? What is a reasonable amount of time before you have to file your suit or lose your rights? Two minutes is not enough time to explain that.

A cap on noneconomic damages. When you lose your sight, lose a limb, what is fair, particularly if you were nonworking, did not have any economic losses? What is fair when you suffer a situation like that? States have dealt with that. The amount in this bill is one of the lowest found anywhere in the country.

The complicated issue of joint and several liability. If everybody agrees that you have got a $100,000 case, how do you ever collect if the HMO is partly at fault, the doctor is partly at fault, maybe the nurse is, maybe the hospital, how do you ever get recovery, particularly if one of them is about to go bankrupt?

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We cannot discuss that in 2 minutes.

The collateral source rule, where you have a person who has paid an insurance premium and has a benefit, who ought to get the benefit of that? Should it be the one that paid the premium, should it be Blue Cross/Blue Shield getting their money back, or should it be the one that created the damage altogether? This bill provides that out of the three, the one that created the problem gets the benefit.

The calculation of the periodic payments, that is a calculated issue. We know with lottery proceeds, you can get a lump sum or get your money strung out. You know if you get the lump sum, you only get half the money. How does this work out? Do they get to just pay half the money, or do they get to spread it out? We do not have time to show that calculation and how unfair this is.

This is not only bad policy, it is a bad process, and I would hope that we would defeat this amendment.

Mr. COX. Mr. Chairman, I yield myself 30 seconds.

Mr. Chairman, in fact, the purpose of this legislation is to make sure that we do not have runaway health care costs and that we have more people insured. The legislation states, and it is worth pointing out, because we have heard something slightly different here, that there will be unlimited damages paid to compensate patients for their medical injuries. Unlimited, without limit.

We are, however, putting some regulations on abuses by lawyers. For example, we want to make sure that there is a fair share rule. If you cause 95 percent of the problem, you pay 95 percent of the damage. That is not the rule today.

Mr. CONYERS. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Mrs. DAVIS).

Mrs. DAVIS of California. Mr. Chairman, I rise today in opposition to the Thomas malpractice amendment. I want you to know that throughout my tenure in the State legislature I supported malpractice reform. I agree with the gentleman from California (Mr. THOMAS) that we do need to address this issue, and I am saddened that this amendment was developed in the middle of the night.

Malpractice reform is too big and too important an issue to be addressed in this hasty, unclear manner. If you want to ask any member of the State legislature over the last few years how they feel about that, I am sure they will reflect that opinion.

I am just not sure if you realize how enormous an issue it is. Do you realize that this bill would put medical malpractice cases in Federal courts for the first time? It is not a small, minor change. It is a major policy decision that should be debated on its own, rather than as a sideline discussion to another major bill.

I am pleased that the gentleman from California (Mr. THOMAS) brought up the letter from the AMA, because if he had only read the second paragraph, I think you would have gotten a different feeling about this letter. It goes on to say, in fact, the AMA policy has long supported medical liability reform. They have in California, it is called MICRA. They appreciate the efforts. But they also say that they have expressed concerns in the past about coupling such reforms with the patients' bill of rights. They are concerned that this amendment could interfere with the ultimate passage of meaningful patients' rights legislation.

I spoke to a physician earlier today who said, yes, complicate it and kill it.

I hope that is not what we are trying to do here.

I know in the State assembly I tried to bring together attorneys and physicians around this matter to develop a compromise on malpractice reform. There is just no way that this House can find the right answer to this important issue without bringing all the parties involved to the table.

If we want effective and responsible malpractice reform, I urge Members to vote against the Thomas amendment.

Mr. COX. Mr. Chairman, I yield myself 10 seconds to point out that the American Medical Association has strongly been in support of these reforms every year I have been in Congress, for 15 years, and their only concern, as the gentlewoman did not let on, is President Clinton, representing the trial lawyers, threatened to veto the legislation if they included the provision they wanted.

Mr. Chairman, I yield 5 minutes to the gentleman from Wisconsin (Mr. SENSENBRENNER), the chairman of the Committee on the Judiciary.

Mr. SENSENBRENNER. Mr. Chairman, the purpose of this amendment is to make sure that health care coverage is more available and affordable to all Americans.

These medical malpractice reform provisions will benefit the American people by limiting costs to doctors, hospitals, and other health care providers, which in turn will improve access to affordable health care insurance for all. Unfortunately, the current medical malpractice litigation is a wealth redistribution lottery that benefits trial lawyers, instead of an efficient system designed to fairly compensate those injured by the wrongful acts of others.

Medical malpractice lawyers often simply target the perceived deep pockets of doctors, hospitals and insurance companies. In many cases, defendants know a lawsuit would not succeed on its merits, but agree to settle out of court just to avoid the endless and expensive legal process. In the end, the lawyers often walk away with as much money as the plaintiff. This injustice raises the price of health care, causes unwarranted personal anguish and unfairly damages reputations.

Doctors and hospitals should be held responsible for truly negligent behavior resulting in actual harm. But a system that perpetuates the concept of joint and several liability has no effective mechanism, such as the cap on noneconomic damages, to deter frivolous lawsuits is simply not just.

America is the only country in the world that provides unlimited compensation for noneconomic damages. Of course, noneconomic damages are separate from and do not include payment for medical costs, lost wages and other out-of-pocket expenses. Therefore, a cap on noneconomic damages would not in any way limit the amount of money an injured plaintiff could receive for their hospital costs, doctor bills, other medical expenses, and lost wages.

Malpractice insurance is expensive because many of the claims brought against doctors and other health care providers are lengthy and frivolous. In the year 2000, the average medical malpractice claim took more than 5 years to settle. Statistics also show that 80 percent of all medical malpractice claims do not even involve a negligent adverse event to the plaintiff. Furthermore, only one out of six plaintiffs who receive compensation from these claims present any evidence of negligent medical injury.

We also have the ever more prevalent problem of doctors practicing defensive medicine. Many doctors are ordering unnecessary and costly medical tests and procedures solely to insulate themselves from potential lawsuit and not for the medical benefit of their patients. For example, conservative estimates predict that with effective medical malpractice tort reform, $600 million a year would be saved in Medicare payments in just the area of treating cardiac disease.

Let me be perfectly clear about who benefits from our current health care liability system: the trial lawyers in America, who continue to line their pockets with each outrageous verdict or settlement. Congress' concern should be helping improve America's health care system, not helping the trial lawyers purchase fancier homes, cars, boats, and country club membership.

This amendment is clearly needed if we are going to make a definitive step today to improve the health care system. The AMA supporters of the Ganske-Dingell patients' bill of rights approach recognized this fact, as was stated by the chairman of the Committee on Ways and Means earlier tonight.

My colleagues, the choice is simple: the more dollars which are spent on medical malpractice lawsuits, insurance premiums and lawyers, the fewer dollars there are for Americans to receive quality medical care. Let us put patients' rights ahead of lawyers' avarice, and support this much needed amendment.

Mr. CONYERS. Mr. Chairman, I yield myself 20 seconds merely to point out to the distinguished floor manager, the gentleman from California (Mr. Cox), that on page 10, section 809, lines 21 and 22, it says, ''This title shall apply to any health care lawsuit brought in a Federal or State court.'' I presume the State court is operating under State law.

Mr. Chairman, I yield 2 minutes to the distinguished gentleman from New York (Mr. NADLER), a member of the Committee on the Judiciary.

Mr. NADLER. Mr. Chairman, a few minutes ago this House by a party-line vote adopted the Norwood amendment which caps punitive damages at $1.5 million and caps noneconomic damages at $1.5 million.

This amendment will take both noneconomic damages, pain and suffering, loss of a limb, and say that a child who lost a limb should be compensated at only $250,000, and punitive damages should be compensated at only $250,000.

If this amendment passes, both amendments will be in place and the bill will totally contradict itself, because in one place it will say $1.5 million and in the other place, $250,000. The attempt by the Republican majority is to kill this bill through poison pill amendments. They have done two contradictory amendments.

Secondly, let me point out that by capping punitive damages at $250,000, the purpose of punitive damages is to deter willful, grossly negligent misconduct. We know of companies that have calculated that they will let people die, they will put unsafe things in their cars or other things, because it is cheaper to pay the damages than to change what they are doing.

Punitive damages are designed to stop that. By limiting punitive damages to $250,000, you will get HMOs that will calculate that it is cheaper to deny medical care, cheaper to pay the economic damages, cheaper to pay the $250,000 limited punitive damages, no matter how willful, how grossly negligent, how deceitful, how willful they may be. It is cheaper to kill people and save money, because we have removed the one deterrent the law has.

This is an amendment that should never be passed. But, of course, it does not really matter, since we already killed the bill, which will never pass the Senate, by putting in the Norwood amendment. But we should not set the precedent of saying to large corporations, calculate the cost benefit. Do things that may kill or maim people if it is cheaper for your bottom line.

Mr. COX. Mr. Chairman, I yield myself 20 seconds to correct the gross, egregious and ought to be subject to punitive damages if we have the kinds of standards we are talking about here in the Congress misstatements of what this amendment is all about.

Punitive damages under this legislation are unlimited. They are not limited to $250,000. The gentleman apparently did not read the amendment. There is a base of $250,000, or twice economic damages, and economic damages are unlimited under this legislation.

He said punitive damages also are limited for health insurance plans or HMOs. This amendment has no application to HMOs or health insurance plans. None.

Mr. CONYERS. Mr. Chairman, I am pleased to yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE), a valued member of the Committee on the Judiciary.

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Chairman, I am glad the distinguished gentleman from California made the

point about this amendment. It has nothing to do with HMOs, so he says, and the patients' bill of rights.

This is the very point that we are making about this amendment. It is clearly a poison pill. It is the adding of a medical malpractice issue. No matter how relevant it may be to the general discussion of medical malpractice, both Federal and State law, it has no relevance in this debate.

The real issue becomes that those who have been fighting for the medical malpractice revisions have done so and have been refuted and rejected for session after session, and they use the patients' bill of rights when we are trying to reestablish the sanctity of the patient and physician relationship to now do this.

The most egregious part of this particular amendment is the cap on noneconomic damages, for what that says is that if you have a child age 5 with the potential of growth, education and opportunity, and through some tragic accident at age 5 they lose their limbs, then you will limit the ability of that child growing into adulthood to be able to be cared for independently by capping the noneconomic damages.

□ 2100

This is not a case of frivolousnes; this is not a case where we are suggesting that there are frivolous lawsuits. This is mean-spirited.

Then, secondarily what this does is it gives the medical device companies, the ones that have the MRI, the ones that have the needles, a buyout. The buyout is, even if they are approved by the FDA, they get a buyout. We know that government agencies are not perfect, so that means if we got some blanket approval 25 years ago for a device, we have no ability, if someone is injured, to recover.

This is heinous. This is, I would say, one of the worst amendments we have, and the American Medical Association will have nothing to do with it, and they should not be misused as they are being misused. Vote this amendment down.

Mr. COX. Mr. Chairman, I yield 2 minutes to the gentleman from Louisiana (Mr. TAUZIN), the chairman of the Committee on Energy and Commerce.

Mr. TAUZIN. Mr. Chairman, as a cosponsor of the amendment, let me first make the point that no one argues, no one can argue, that unnormally high, runaway malpractice jury awards harms our health care. First of all, it raises costs, it absolutely raises the cost of medical malpractice insurance of physicians and gets passed on to all of us.

Secondly, we all know what it does to physicians. It sends a chilling effect to physicians around the country who end up practicing defensive medicine; in fact, doing things not necessary, not required, just to protect themselves from the lawyers who might end up suing them.

Today, we can do something about it. We can pass this amendment modeled after the California law.

What is beautiful about this amendment is that not only does this amendment place some caps on those runaway charges that juries sometimes make that we all pay for, but it does so in a way that does not preempt the State law. For example, if your State caps noneconomic damages at $500,000, so be it. If your State has any cap on punitive damages, then your State law in that area is preserved. If your State wants to place a $500,000 cap on punitive damages 3 years from now, it is permitted to do so under this amendment.

In short, our authors have put this amendment together in such a way that it helps a number of States restrain runaway malpractice costs and, at the same time, preserves your State's ability to do it differently if you want to do it differently in your State.

Mr. Chairman, this is modest medical malpractice reform. We passed some recently on medical devices that were going out of business, not because they were losing lawsuits; simply because the cost of defending the lawsuits was driving the companies out of the business of making things, like shunts for kids with hydrocephalic cases or limbs for children who have lost their limbs to cancer.

When we passed that medical malpractice reform a few years ago, those manufacturers went back into business. Today, we have a chance to keep our health care system in business. Pass this good amendment.

Mr. CONYERS. Mr. Chairman, I yield myself 1½ minutes to first, hopefully correct the chairman of the Committee on the Judiciary, the gentleman from Wisconsin (Mr. SENSENBRENNER), who asserted that lawyers were getting huge fees. All fees, most Members know, are controlled by the court. Any exorbitant fees are not permitted. And from time immemorial, lawyers get one-third of the recovery. If that is what we are complaining about, we should make it clear that anything more excessive is controlled by the court.

Then, the gentleman from California (Mr. COX), the floor manager, has asserted that the bill does not cap punitive damages. Now if, unfortunately, a physician rapes a patient, many would say she has no economic damages, she may have no lost wages and negligible medical costs. So the Cox amendment would, in that case, cap her punitive damages at $250,000.

Mr. COX. Mr. Chairman, that is false. That is false. The gentleman must yield on that point.

Mr. CONYERS. Sir, control yourself.

So, I say to the gentleman from California (Mr. COX), it is incorrect, I repeat, incorrect to assert that this amendment does not cap punitive damages. If the gentleman takes issue with that, he may use his own time and explain to the membership what he disagrees about.

Mr. Chairman, I yield 1 minute to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I stood on this floor arguing for medical malpractice reform, and I continued before that, but not on this bill.

Let me read to my colleagues from a letter from the AMA on this. ''AMA policy has long supported medical liability reform, and we appreciate your efforts in this regard. As you know, we have expressed concerns in the past about coupling such reforms with the Patients' Bill of Rights. As we enter into the conference for the Patients' Bill of Rights, it continues to be our hope that controversy surrounding this amendment will not interfere with the ultimate passage of a meaningful Patients' Bill of Rights.''

We have just passed an amendment that I think will make the conference more difficult. I think if this amendment to this bill passes, the conference will be really difficult. I continue to be a supporter for medical malpractice reform. I would like to see it come up another time.

I urge a no vote on this amendment.

Mr. COX. Mr. Chairman, I yield myself 45 seconds to correct the record.

We have the right of free speech here on the floor of the House, but it is very important that we stick to the facts. The bill says very clearly that, first of all, punitive damages are not limited, but rather, they are fixed in amount, in a variable amount that can rise to infinity at twice economic damages.

Second, the gentleman from Michigan stated an outrageous example. He says if a physician rapes someone, that they would somehow be shielded from liability by this amendment or some other act of Congress. What this amendment very clearly states is that anyone who specifically intends to cause harm has no place in this provision. It does not apply.

Mr. Chairman, I yield 1 minute to the gentleman from Kentucky (Mr. FLETCHER), the author of so much of the good work that the President and the Congress are bringing to the floor today.

Mr. FLETCHER. Mr. Chairman, as a practicing physician, the possibility of malpractice was always there in the back of your mind, because you wanted to make sure you delivered the most quality care you could to your patients.

I can think of generally, probably a day did not go by when there were things that you felt like, well, I do not really think we need this, but because of the way malpractice is, we are going to order a specific test. A patient that comes in with a headache, you may not see them again for a while, and you order an $800 or a $1,000 MRI just to make sure that if something happens way in the future that you do not incur some sort of frivolous lawsuit.

But let me talk about a couple of things. One, according to Daniel P. Kessler, an associate professor at Stanford Business School, when he looked

at direct costs, he said they may be relatively small, the direct costs of liability. I think clearly we can say they are fairly significant. But they are small relative to the indirect costs which he estimates five times.

For that reason and for the quality of care, to make sure that we do not promote defensive medicine, I urge my colleagues to support this, as most of the physicians across the country would agree.

Mr. CONYERS. Mr. Chairman, I am pleased to yield 1 minute to the gentlewoman from Ohio (Mrs. JONES), a lawyer, prosecutor, and former judge.

Mrs. JONES of Ohio. Mr. Chairman, as we sit here debating a Patients' Bill of Rights, we stopped talking about the patients' rights and started reading letters from the AMA saying, well, I do not want the doctors to be any more liable, the HMOs, so we are happy with the legislation.

I would suggest to those of my colleagues on the floor of this House, walk a mile in the shoes of someone who has been injured, walk a mile in the shoes of a family member who has a child that has been maimed or blinded, and you will not be talking about limits, you will be talking about, let me get to court and establish my damages, and if I establish them, pay me; and if they have been negligent or extremely negligent, let me get punitive damages.

Let us get realistic, I say to my colleagues. We as significant Members of Congress can pass legislation that will not be questionable, that will not be left to a court to interpret. We can make it clear to the people of these United States that we are going to stand up for patients' rights, that we are going to stand up and allow them to collect if they are damaged.

Mr. COX. Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania (Mr. TOOMEY).

Mr. TOOMEY. Mr. Chairman, I thank the gentleman from California for yielding time.

I would like to commend the sponsors of this amendment. I introduced bills both in the previous Congress and in this Congress that are substantially the same as this amendment, so I am grateful that we are going to have a chance to include this in legislation that is moving.

Why do we need medical malpractice reform? It is simple. Medical malpractice awards are out of control. Medical malpractice awards are draining millions of dollars from health care and putting it into courtrooms and trial lawyers. They are contributing significantly to the staggering increase in health care costs. They are forcing doctors to practice defensive medicine to protect themselves against, very often, meritless claims, and these awards are forcing some doctors to leave their specialties altogether.

My State of Pennsylvania has been particularly hard hit by what is now a legal system run amok. We rank second in the Nation in medical malpractice judgments. We suffer through jury verdicts that are amongst the highest, twice the level of California, which has this kind of medical malpractice reform. As a result, doctors in my State often pay premiums that are twice the level of California, often over $100,000 a year just for insurance; good doctors who have never harmed a soul, who have never been negligent.

Mr. Chairman, this is long overdue. This provision applies to all health care providers; it provides reasonable parameters on awards. It eliminates the insidious application of joint and several liability; and that, in layman terms, simply means that defendants will be required to pay judgments in proportion to their responsibility, not in proportion to the thickness of their wallet.

Finally, Mr. Chairman, many of us are concerned that what we do here in Washington respect the rights of the States. This amendment does exactly that. This amendment says that if there is a State that has a medical malpractice law on the books, then that State law will prevail. If a State has no law whatsoever, then this amendment would prevail. If a State has no law and subsequently chooses to pass a law, then this would become irrelevant in that State; the State law would then once again prevail. This respects States' rights. This is going to help restore funding to health care instead of to trial lawyers.

I urge my colleagues to support this amendment.

Mr. CONYERS. Mr. Chairman, I reserve my time.

Mr. COX. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Louisiana (Mr. MCCRERY), a member of the Committee on Ways and Means.

Mr. MCCRERY. Mr. Chairman, placing reasonable caps on medical malpractice will help us, as the gentleman from Louisiana pointed out (Mr. TAUZIN), to fight health care inflation. In 1999, fully 13 percent of our gross domestic product went to health care expenses. That number will climb to almost 16 percent before this decade is over. At some point, this trend becomes unsustainable and some sort of national health care system in which politicians ration health care becomes inevitable.

Our medical malpractice system is a drag on the health care system in many ways. Dollars spent on lawyers, enormous jury awards and settlements to avoid litigation are not being spent on patient care. Data from the insurance analyst A.M. Best show that injured claimants received less than one-third of total malpractice premiums in 1996, while attorneys' fees, the cost of expert witnesses and other court costs eat up more than half.

The fear of being sued encourages defensive medicine, extra tests and procedures which may help insulate physicians from being sued, but do nothing for patients, other than add to their bills. The amendment before us strikes an appropriate balance. It permits States to enact their own medical malpractice laws, if they wish, but it does set a standard which will govern malpractice actions in States which have failed to enact their own reforms.

Finally, it is critical to remember that nothing in this amendment denies injured plaintiffs from obtaining adequate redress, including compensation for 100 percent of their economic losses, their medical costs, their lost wages, future lost wages. Instead, though, this amendment places reasonable limits on noneconomic and punitive damages.

As the American Medical Association noted in testimony in 1996, ''While these can be emotionally charged issues, the fact remains that the current tort system, driven as it is by the potential for unlimited attorneys' fees and unlimited compensation for intangible losses, is unable to resolve medical liability claims effectively and efficiently.''

□ 2115

''Moreover, even with the cap of a quarter of a million dollars, the United States would be the most generous country in the world in compensating for noneconomic losses.''

This is a balanced amendment. It will do great good for our health care system in this country.

Mr. CONYERS. Mr. Chairman, I reserve my time.

Mr. COX. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania (Mr. GREENWOOD), a member of the Committee on Energy and Commerce.

Mr. GREENWOOD. Mr. Chairman, I thank the gentleman for yielding me time.

In my State of Pennsylvania, it was not very long ago that when I looked at the medical community I saw a group of folks doing pretty well. They seemed to have a nice income. They seemed to be enjoying their profession. They seemed to be on top of the world.

In the last 15 years or so I have seen a dramatic change in my doctors from the State of Pennsylvania. I have seen them hit with medical malpractice rates that are phenomenal, a 45 percent increase in the medical malpractice rates just in the last year in the State of Pennsylvania.

I knew a physician. He was a good orthopedist, one of the best. All he liked to do was get up in the morning and fix broken bones. His medical malpractice rates got so high that his daughter secretly paid his premiums for him just so he would not give up and quit. Finally, when he found out how high those premiums were, he left the State of Pennsylvania and we lost one of our finest physicians.

The doctors in my State of Pennsylvania have had it. We have got to pass this medical malpractice tonight.

Mr. CONYERS. Mr. Chairman, I yield 1 minute to the gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Chairman, last night one could watch network TV or C–SPAN and by switching back and forth one could watch two shows, ''Let's Make a Deal'' and ''The Price Is Right.'' If one listened very closely in the middle of night, one could almost hear the White House say, Come on down. You are our next contestant.

We still do not know what was behind doors 1, 2, or 3; and we are wondering what the grand prize was. We know this amendment was filed for political cover. Let us be straight about it. That being said, let us get to the facts.

All of us are concerned about the high cost of medical care. However, medical malpractice does not contribute to that. An October 1992 study of the Congressional Budget Office concluded and said:

Malpractice insurance premiums account for less than one penny of each dollar spent annually on the Nation's health care.

A study funded by the Texas Medical Association, the Trial Lawyers' Association, the Texas Hospital Association said:

Changing the medical professional liability system will have minimal cost savings impact on their overall health care delivery system in Texas.

Many factors contribute to increased medical costs. This is not one of them. Vote no on Thomas-Cox. It is pure politics. We know it. It is nothing more and the patients lose.

PARLIAMENTARY INQUIRY

Mr. COX. Mr. Chairman, does the minority have the right to close?

The CHAIRMAN. The gentleman from California has the right to close.

Mr. COX. Mr. Chairman, I yield myself 5 seconds to observe that this Chamber has on many occasions passed legislation of this type, and it has been scored by the Congressional Budget Office as saving $1.5 billion.

Mr. Chairman, I reserve the balance of my time.

PARLIAMENTARY INQUIRY

Mr. CONYERS. Parliamentary inquiry, Mr. Chairman.

The CHAIRMAN. The chair finds that the gentleman from Michigan is not a ''manager'' of the pending measure within the meaning of clause 3(c) of rule XVII. Consequently, the gentleman from California has the right to close.

Mr. CONYERS. Mr. Chairman, I thank the Chair for answering my anticipated question.

Mr. Chairman, I yield the balance of my time to the gentlewoman from Colorado (Ms. DEGETTE).

The CHAIRMAN. The gentlewoman is recognized for 1¼ minutes.

Ms. DEGETTE. Mr. Chairman, if this amendment passes, this bill will have completed its transformation from the Patients' Bill of Rights, to the providers' bill of rights. Make no mistake about it, under the Norwood amendment which just passed, patients will never be able to hold HMOs legally accountable because of an unreasonable burden of proof.

If this amendment is passed, patients will now not be adequately compensated for their damages that they incur as a result of malpractice by doctors or any other providers.

My colleague, the gentleman from California (Mr. COX), says incorrectly that the bill provides unlimited economic damages. But he knows as well as everybody else here that State statutes limit economic damages to actual money paid out of pocket. So if there is someone who has medical bills of $2,000 and they have noneconomic damages of $1 million, too bad. They are out of court. The only noneconomic damages they can get would be $4,000 under this amendment.

Now where will this apply? In some of the most tragic situations, loss of a limb or sight, the loss of mobility, the loss of fertility, excruciating pain and permanent and severe disfigurement, also, the loss of a child or a spouse. There are a number of other damages that are limited. Do not take this out on the patients. Vote no on this amendment.

Mr. COX. Mr. Chairman, I yield myself 15 seconds while they are setting up the chart to correct the misunderstanding of the gentlewoman.

She described a situation in which there were for some reason, under State law, a limit on economic damages, there is no such limit in this bill, and that the limit amounted to $2,000 in a case and that that would mean twice the economic damages would be a $4,000 limit under this bill. But she misunderstands it because the limit in that case would be a quarter million dollars. That is the limit that would apply, the greater, not the lesser, of twice the economic damages or a quarter million dollars.

Mr. Chairman, I will inquire how much time remains.

The CHAIRMAN. The gentleman from California has 2 minutes remaining.

Mr. COX. Mr. Chairman, I yield myself my remaining time.

Mr. Chairman, I wish to address the Chamber from the floor because I wanted to draw attention to this chart.

This describes the situation in America today in which insurance premiums paid by all of us here in this Chamber are distributed unequally to pay the costs of lawsuit abuse: 32.46 percent going to pay injured claimants; and 52 percent to pay attorneys, witnesses, expert witnesses, and other court expenses. That is wrong, and we are here to fix it.

There is virtually a constitutional right in America to bring a bad lawsuit, and we count on the courts to throw the bad ones out. But in the Federal system today, because the courts are so busy, 93 percent of cases never get a single day of trial.

That creates enormous opportunity for mischief, because then people can extort settlements, since everyone knows how expensive it is to wait it out and pay their lawyers while they finally might be one of the 7 percent of cases that get their day in court.

We want to adopt a ''fair share'' rule. We want to say that if one committed 5 percent of the problem, then pay 5 percent of the damages. Let us say that a rapist drug dealer staggers into the emergency room with a knife wound and demands, in his drug-induced haze, to be operated on, and gives the emergency room fits.

The surgeon that works on him does the best he can, but it is not perfect. The drug dealer and rapist sues. The jury finds he is 95 percent responsible for his own knife wounds, but 5 percent of the problem lies with the hospital, because the physician was working too long.

Today the hospital, us, the premium payer, can be made to pay 100 percent because the drug dealer is without means. We want a fair share rule because if one pays premiums, one should not be denied health care in that way.

Everyone knows this bill, which is very important, which we are going to pass, which expands patient protections, is going to raise the cost of insurance. We are trying to find ways to regulate it.

If Members believe that all doctors are bad and all lawyers are good, this amendment is not for them. But if Members believe that some lawyers need some regulation, as well as HMOs getting regulation properly in this bill, vote aye for lower health care premiums and more access to health care.

Mr. SHAYS. Mr. Chairman, I rise in support of the Thomas-Cox amendment. As one who has long supported reforming our medical malpractice laws, I am pleased to support this amendment.

This amendment is similar to legislation Mr. GREENWOOD and I introduced, the Medical Malpractice Rx Act, which will help prevent frivolous, excessive lawsuits that are driving up the cost of health care, forcing doctors to practice defensive medicine, and making access to affordable health insurance more difficult for the average American.

Only 40 cents of every dollar paid to litigate and settle malpractice cases is ever paid to the actual victims. Lawsuits impose unnecessarily high litigation costs on all parties and these costs are then passed along to consumers. The rate of malpractice cases has doubled in the past ten years and on average 120,000 lawsuits are filed against America's 500,000 physicians at any one time. That's one lawsuit for every four doctors.

It is imperative we adopt the Thomas-Cox amendment to discourage abuse of our legal system and curb the unsustainable growth of medical costs in our country. I urge my colleagues on both sides of the aisle to vote in favor of this amendment.

The CHAIRMAN. The question is on the amendment offered by the gentleman from California (Mr. THOMAS).

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. CONYERS. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 207, noes 221, not voting 5, as follows:

[Roll No. 330]

AYES—207

Aderholt	Granger	Platts
Akin	Graves	Pombo
Armey	Green (WI)	Portman
Bachus	Greenwood	Pryce (OH)
Baker	Gutknecht	Putnam
Ballenger	Hansen	Quinn
Barr	Hart	Radanovich
Bartlett	Hastings (WA)	Ramstad
Barton	Hayes	Regula
Bass	Hayworth	Rehberg
Bereuter	Hefley	Reynolds
Biggert	Herger	Riley
Bilirakis	Hilleary	Rogers (KY)
Blunt	Hobson	Rogers (MI)
Boehlert	Hoekstra	Rohrabacher
Boehner	Horn	Ros-Lehtinen
Bonilla	Hostettler	Roukema
Bono	Houghton	Royce
Brady (TX)	Hulshof	Ryan (WI)
Brown (SC)	Hunter	Ryun (KS)
Bryant	Hutchinson	Saxton
Burr	Hyde	Scarborough
Burton	Isakson	Schaffer
Buyer	Issa	Schrock
Callahan	Johnson (CT)	Sensenbrenner
Calvert	Johnson, Sam	Sessions
Camp	Jones (NC)	Shadegg
Cannon	Keller	Shaw
Cantor	Kelly	Shays
Capito	Kennedy (MN)	Sherwood
Castle	Kerns	Shimkus
Chabot	Kingston	Shuster
Coble	Kirk	Simmons
Collins	Knollenberg	Simpson
Combest	Kolbe	Skeen
Cooksey	LaHood	Smith (MI)
Cox	Largent	Smith (NJ)
Cramer	Latham	Smith (TX)
Crane	Leach	Souder
Crenshaw	Lewis (CA)	Stearns
Cubin	Lewis (KY)	Stenholm
Culberson	Linder	Stump
Cunningham	LoBiondo	Sununu
Davis, Jo Ann	Lucas (KY)	Sweeney
Davis, Tom	Lucas (OK)	Tancredo
Deal	Manzullo	Tauzin
DeLay	McCrery	Taylor (NC)
DeMint	McHugh	Thomas
Doolittle	McInnis	Thornberry
Dreier	McKeon	Thune
Dunn	Mica	Tiahrt
Ehlers	Miller (FL)	Tiberi
English	Miller, Gary	Toomey
Everett	Moran (KS)	Traficant
Ferguson	Myrick	Upton
Flake	Ney	Vitter
Fletcher	Northup	Walden
Foley	Norwood	Walsh
Forbes	Nussle	Wamp
Fossella	Osborne	Watkins (OK)
Frelinghuysen	Ose	Watts (OK)
Gallegly	Otter	Weldon (FL)
Gekas	Oxley	Weldon (PA)
Gibbons	Pence	Weller
Gilchrest	Peterson (MN)	Whitfield
Gillmor	Peterson (PA)	Wilson
Goode	Petri	Wolf
Goodlatte	Pickering	Young (AK)
Goss	Pitts	Young (FL)

NOES—221

Abercrombie	Boucher	Davis (CA)
Ackerman	Boyd	Davis (FL)
Allen	Brady (PA)	Davis (IL)
Andrews	Brown (FL)	DeFazio
Baca	Brown (OH)	DeGette
Baird	Capps	Delahunt
Baldacci	Capuano	DeLauro
Baldwin	Cardin	Deutsch
Barcia	Carson (IN)	Diaz-Balart
Barrett	Carson (OK)	Dicks
Becerra	Chambliss	Dingell
Bentsen	Clay	Doggett
Berkley	Clayton	Dooley
Berman	Clement	Doyle
Berry	Clyburn	Duncan
Bishop	Condit	Edwards
Blagojevich	Conyers	Ehrlich
Blumenauer	Costello	Emerson
Bonior	Coyne	Engel
Borski	Crowley	Eshoo
Boswell	Cummings	Etheridge
Evans	Lantos	Rangel
Farr	Larsen (WA)	Reyes
Fattah	Larson (CT)	Rivers
Filner	LaTourette	Rodriguez
Ford	Lee	Roemer
Frank	Levin	Ross
Frost	Lewis (GA)	Rothman
Ganske	Lofgren	Roybal-Allard
Gephardt	Lowey	Rush
Gilman	Luther	Sabo
Gonzalez	Maloney (CT)	Sanchez
Gordon	Maloney (NY)	Sanders
Graham	Mascara	Sandlin
Green (TX)	Matheson	Sawyer
Grucci	Matsui	Schakowsky
Gutierrez	McCarthy (MO)	Schiff
Hall (OH)	McCarthy (NY)	Scott
Hall (TX)	McCollum	Serrano
Harman	McDermott	Sherman
Hastings (FL)	McGovern	Shows
Hill	McIntyre	Skelton
Hilliard	McKinney	Slaughter
Hinchey	McNulty	Smith (WA)
Hinojosa	Meehan	Snyder
Hoeffel	Meek (FL)	Solis
Holden	Meeks (NY)	Spratt
Holt	Menendez	Stark
Honda	Millender-McDonald	Strickland
Hooley	Miller, George	Stupak
Hoyer	Mink	Tanner
Inslee	Mollohan	Tauscher
Israel	Moore	Taylor (MS)
Istook	Moran (VA)	Terry
Jackson (IL)	Morella	Thompson (MS)
Jackson-Lee (TX)	Murtha	Thurman
Jefferson	Nadler	Tierney
Jenkins	Napolitano	Towns
John	Neal	Turner
Johnson (IL)	Nethercutt	Udall (CO)
Johnson, E. B.	Oberstar	Udall (NM)
Jones (OH)	Obey	Velazquez
Kanjorski	Olver	Visclosky
Kaptur	Ortiz	Waters
Kennedy (RI)	Owens	Watson (CA)
Kildee	Pallone	Watt (NC)
Kilpatrick	Pascrell	Waxman
Kind (WI)	Pastor	Weiner
King (NY)	Payne	Wexler
Kleczka	Pelosi	Wicker
Kucinich	Phelps	Woolsey
LaFalce	Pomeroy	Wu
Lampson	Price (NC)	Wynn
Langevin	Rahall	

NOT VOTING—5

Lipinski	Paul	Thompson (CA)
Markey	Spence	

□ 2146

Mr. ENGLISH changed his vote from ''no'' to ''aye.''

So the amendment was rejected.

The result of the vote was announced as above recorded.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. BEREUTER) having assumed the chair, Mr. LAHOOD, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2563) 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, pursuant to House Resolution 219, he reported the bill back to the House with sundry amendments adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. BERRY

Mr. BERRY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. BERRY. Yes, Mr. Speaker, in its current form I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. BERRY moves to recommit the bill H.R. 2563 to the Committee on Ways and Means, the Committee on Energy and Commerce, and the Committee on Education and the Workforce with instructions that each report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Patient Protection Act''.

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

TITLE I—IMPROVING MANAGED CARE

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

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 102.

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

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a participant, beneficiary, or enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for a periodic evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

SEC. 102. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

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

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to

make with respect to such claim for benefits, and of the right of the participant, beneficiary, or enrollee to an internal appeal under section 103.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial 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 claim. 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 subsection (b)(1), 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.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claim for such benefits without regard to whether and when a written confirmation of such request is made.

(b) TIMELINE FOR MAKING DETERMINATIONS.—

(1) PRIOR AUTHORIZATION DETERMINATION.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization and in no case later than 28 days after the date of the claim for benefits is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, and a health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on a claim for benefits described in such subparagraph when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain 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 is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE.—

(i) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an appeal under section 103(b)(3) to be completed before the termination or reduction takes effect.

(II) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) RETROSPECTIVE DETERMINATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination (or, in the case described in subparagraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph).

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(2) the procedures for obtaining additional information concerning the determination; and

(3) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with section 103.

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

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

SEC. 103. INTERNAL APPEALS OF CLAIMS DENIALS.

(a) RIGHT TO INTERNAL APPEAL.—

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

(2) TIME FOR APPEAL.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall ensure that a participant, beneficiary, or enrollee (or authorized 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 participant, beneficiary, enrollee, or representative proceed directly to seek further appeal through external review under section 104 or otherwise.

(b) TIMELINES FOR MAKING DETERMINATIONS.—

(1) ORAL REQUESTS.—In the case of an appeal of a denial of a claim for benefits under this section that involves an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may request such appeal orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for an appeal of a denial, the making of the request (and the timing of such request) shall be treated as the

making at that time of a request for an appeal without regard to whether and when a written confirmation of such request is made.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an appeal of a 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.

(3) PRIOR AUTHORIZATION DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in this paragraph or paragraph (4), a group health plan, and a health insurance issuer offering health insurance coverage, shall make a determination on an appeal of a denial of a claim for benefits under this subsection in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 28 days after the date the request for the appeal is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, and a health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on an appeal of a denial of a claim for benefits described in subparagraph (A), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain 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 such appeal is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE DETERMINATIONS.—

(i) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review determination described in section 102(b)(1)(C)(i)(I), which results in a termination or reduction of such care, the plan or issuer must provide notice of the determination on the appeal under this section by telephone and in printed form to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an external appeal under section 104 to be completed before the termination or reduction takes effect.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(4) RETROSPECTIVE DETERMINATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a denial of a claim for benefits in no case later than 30 days after the date on which the plan or issuer receives necessary information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 60 days after the date the request for the appeal is received.

(c) CONDUCT OF REVIEW.—

(1) IN GENERAL.—A review of a denial of a claim for benefits under this section shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

(2) PEER REVIEW OF MEDICAL DECISIONS BY HEALTH CARE PROFESSIONALS.—A review of an appeal of a denial of a claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts—

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

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

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

(d) NOTICE OF DETERMINATION.—

(1) IN GENERAL.—Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of completion of the review (or, in the case described in subparagraph (B) or (C) of subsection (b)(3), within the 72-hour or applicable period referred to in such subparagraph).

(2) FINAL DETERMINATION.—The decision by a plan or issuer under this section shall be treated as the final determination of the plan or issuer on a denial of a claim for benefits. The failure of a plan or issuer to issue a determination on an appeal of a denial of a claim for benefits under this section within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits for purposes of proceeding to external review under section 104.

(3) REQUIREMENTS OF NOTICE.—With respect to a determination made under this section, the notice described in paragraph (1) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

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

(C) notification of the right to an independent external review under section 104 and instructions on how to initiate such a review.

SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide in accordance with this section participants, beneficiaries, and enrollees (or authorized representatives) with access to an independent external review for any denial of a claim for benefits.

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

(1) TIME TO FILE.—A request for an independent external review under this section shall be filed with the plan or issuer not later than 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the denial under section 103(d) or notice of waiver of internal review under section 103(a)(4) or the date on which the plan or issuer has failed to make a timely decision under section 103(d)(2) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(2) FILING OF REQUEST.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a group health plan, or health insurance issuer offering health insurance coverage, may—

(i) except as provided in subparagraph (B)(i), require that a request for review be in writing;

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

(iii) except if waived by the plan or issuer under section 103(a)(4), condition access to an independent external review under this section upon a final determination of a denial of a claim for benefits under the internal review procedure under section 103;

(iv) except as provided in subparagraph (B)(ii), require payment of a filing fee to the plan or issuer of a sum that does not exceed $25; and

(v) require that a request for review include the consent of the participant, beneficiary, or enrollee (or authorized representative) for the release of necessary medical information or records of the participant, beneficiary, or enrollee to the qualified external review entity only for purposes of conducting external review activities.

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(i) ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request for such review may be made orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such a review without regard to whether and when a written confirmation of such request is made.

(ii) EXCEPTION TO FILING FEE REQUIREMENT.—

(I) INDIGENCY.—Payment of a filing fee shall not be required under subparagraph (A)(iv) where there is a certification (in a form and manner specified in guidelines established by the appropriate Secretary) that

the participant, beneficiary, or enrollee is indigent (as defined in such guidelines).

(II) FEE NOT REQUIRED.—Payment of a filing fee shall not be required under subparagraph (A)(iv) if the plan or issuer waives the internal appeals process under section 103(a)(4).

(III) REFUNDING OF FEE.—The filing fee paid under subparagraph (A)(iv) shall be refunded if the determination under the independent external review is to reverse or modify the denial which is the subject of the review.

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

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

(1) IN GENERAL.—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering health insurance coverage, the plan or issuer shall immediately refer such request, and forward the plan or issuer's initial decision (including the information described in section 103(d)(3)(A)), to a qualified external review entity selected in accordance with this section.

(2) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant, beneficiary, or enrollee (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with information that is necessary to conduct a review under this section, as determined and requested by the entity. Such information 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 clause (ii) or (iii) of subsection (e)(1)(A), by such earlier time as may be necessary to comply with the applicable timeline under such clause.

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

(A) IN GENERAL.—With respect to a request referred to a qualified external review entity under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless the entity determines that—

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

(ii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

(iii) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant, beneficiary, or enrollee who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

(iv) the denial of the claim for benefits is a decision as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage unless the decision is a denial described in subsection (d)(2).

Upon making a determination that any of clauses (i) through (iv) applies with respect to the request, the entity shall determine that the denial of a claim for benefits involved is not eligible for independent medical review under subsection (d), and shall provide notice in accordance with subparagraph (C).

(B) PROCESS FOR MAKING DETERMINATIONS.—

(i) NO DEFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no deference given to determinations made by the plan or issuer or the recommendation of a treating health care professional (if any).

(ii) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified personnel to make determinations under this section.

(C) NOTICES AND GENERAL TIMELINES FOR DETERMINATION.—

(i) NOTICE IN CASE OF DENIAL OF REFERRAL.—If the entity under this paragraph 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 determination within the overall timeline that is applicable to the case under review as described in subsection (e), except that if the entity determines that a referral to an independent medical reviewer is not required, the entity shall provide notice of such determination to the participant, beneficiary, or enrollee (or authorized representative) within such timeline and within 2 days of the date of such determination.

(d) INDEPENDENT MEDICAL REVIEW.—

(1) IN GENERAL.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial involved to an independent medical reviewer for the conduct of an independent medical review under this subsection.

(2) MEDICALLY REVIEWABLE DECISIONS.—A denial of a claim for benefits is eligible for independent medical review if the benefit for the item or service for which the claim is made would be a covered benefit under the terms and conditions of the plan or coverage but for one (or more) of the following determinations:

(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—A determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—A determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms.

(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(A) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to whether or not the denial of a claim for a benefit that is the subject of the review should be upheld, reversed, or modified.

(B) STANDARD FOR DETERMINATION.—The independent medical reviewer's determination relating to the medical necessity and appropriateness, or the experimental or investigational nature, or the evaluation of the medical facts, of the item, service, or condition involved shall be based on the medical condition of the participant, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.

(C) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)). Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage documents) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required: *Provided,* That the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

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

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

(ii) The recommendation of the treating health care professional and the evidence, guidelines, and rationale used by the treating health care professional in reaching such recommendation.

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

(iv) The plan or coverage document.

(E) INDEPENDENT DETERMINATION.—In making determinations under this section, a qualified external review entity and an independent medical reviewer shall—

(i) consider the claim under review 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

(iii) with respect to a determination to reverse or modify the denial under review, a timeframe within which the plan or issuer must comply with such determination.

(G) NONBINDING NATURE OF ADDITIONAL RECOMMENDATIONS.—In addition to the determination under subparagraph (F), the reviewer may provide the plan or issuer and the treating health care professional with additional recommendations in connection with such a determination, but any such recommendations shall not affect (or be treated as part of) the determination and shall not be binding on the plan or issuer.

(e) TIMELINES AND NOTIFICATIONS.—

(1) TIMELINES FOR INDEPENDENT MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION DETERMINATION.—

(i) IN GENERAL.—The independent medical reviewer (or reviewers) shall make a determination on a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days after the date of receipt of information under subsection (c)(2) if the review involves a prior authorization of items or services and in no case later than 21 days after the date the request for external review is received.

(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i) and subject to clause (iii), the independent medical reviewer (or reviewers) shall make an expedited determination on a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination, and a health care professional certifies, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain 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 case later than 60 days after the date the request for external review is received by the qualified external review entity.

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) receives a copy of the written determination of the independent medical reviewer prepared under subsection (d)(3)(F). Nothing in this paragraph shall be construed as preventing an entity or reviewer from providing an initial oral notice of the reviewer's determination.

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

(f) COMPLIANCE.—

(1) APPLICATION OF DETERMINATIONS.—

(A) EXTERNAL REVIEW DETERMINATIONS BINDING ON PLAN.—The determinations of an external review entity and an independent medical reviewer under this section shall be binding upon the plan or issuer involved.

(B) COMPLIANCE WITH DETERMINATION.—If the determination of an independent medical reviewer is to reverse or modify the denial, the plan or issuer, upon the receipt of such determination, shall authorize coverage to comply with the medical reviewer's determination in accordance with the timeframe established by the medical reviewer.

(2) FAILURE TO COMPLY.—

(A) IN GENERAL.—If a plan or issuer fails to comply with the timeframe established under paragraph (1)(B) with respect to a participant, beneficiary, or enrollee, where such failure to comply is caused by the plan or issuer, the participant, beneficiary, or enrollee may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

(B) REIMBURSEMENT.—

(i) IN GENERAL.—Where a participant, beneficiary, or enrollee obtains items or services in accordance with subparagraph (A), the plan or issuer involved shall provide for reimbursement of the costs of such items or services. Such reimbursement shall be made to the treating health care professional or to the participant, beneficiary, or enrollee (in the case of a participant, beneficiary, or enrollee who pays for the costs of such items or services).

(ii) AMOUNT.—The plan or issuer shall fully reimburse a professional, participant, beneficiary, or enrollee under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items or services) so long as the items or services were provided in a manner consistent with the determination of the independent medical reviewer.

(C) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant, beneficiary, or enrollee in accordance with this paragraph, the professional, participant, beneficiary, or enrollee may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is owed by the plan or issuer and any necessary legal costs or expenses (including attorney's fees) incurred in recovering such reimbursement.

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

(3) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(A) MONETARY PENALTIES.—

(i) IN GENERAL.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion of a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(ii) ADDITIONAL PENALTY FOR FAILING TO FOLLOW TIMELINE.—In any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant, beneficiary, or enrollee involved.

(B) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in subparagraph (A) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such subparagraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity to be covered, or has failed to take an action for which such person is responsible under the terms and conditions of the plan or coverage and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(i) to cease and desist from the alleged action or failure to act; and

(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(C) ADDITIONAL CIVIL PENALTIES.—

(i) IN GENERAL.—In addition to any penalty imposed under subparagraph (A) or (B), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(I) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity to be covered; or

(II) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or coverage.

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

(I) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice; or

(II) $500,000.

(D) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in subparagraph (C)(i) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(4) PROTECTION OF LEGAL RIGHTS.—Nothing in this subsection or subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the

right to file judicial actions to enforce rights.

(g) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—

(1) IN GENERAL.—In referring a denial to 1 or more individuals to conduct independent medical review under subsection (c), the qualified external review entity shall ensure that—

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

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

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

(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

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

(3) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

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

(ii) not have a material familial, financial, or professional relationship with such a party; and

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

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

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

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

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

(III) the fact of such an affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative) and neither party objects; and

(IV) the affiliated individual is not an employee of the plan or issuer and does not provide services exclusively or primarily to or on behalf of the plan or issuer;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative), and neither party objects; or

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

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

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

(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

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

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

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

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

(A) not exceed a reasonable level; and

(B) not be contingent on the decision rendered by the reviewer.

(7) RELATED PARTY DEFINED.—For purposes of this section, the term ''related party'' means, with respect to a denial of a claim under a plan or coverage relating to a participant, beneficiary, or enrollee, any of the following:

(A) The plan, plan sponsor, or issuer involved, or any fiduciary, officer, director, or employee of such plan, plan sponsor, or issuer.

(B) The participant, beneficiary, or enrollee (or authorized representative).

(C) The health care professional that provides the items or services involved in the denial.

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

(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

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

(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

(1) SELECTION OF QUALIFIED EXTERNAL REVIEW 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 State in a manner determined by the State to assure an unbiased determination.

(2) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).

(3) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—

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

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

Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(iv) or costs incurred by the participant, beneficiary, or enrollee (or authorized representative) or treating health care professional (if any) in support 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 activities consistent with the applicable requirements of this section and standards specified in subparagraph (C), including that it will not conduct any external review activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).

(v) The entity meets such other requirements as the appropriate Secretary provides by regulation.

(B) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—

(I) is not a related party (as defined in subsection (g)(7));

(II) does not have a material familial, financial, or professional relationship with such a party; and

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

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

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—

(I) not exceed a reasonable level; and

(II) not be contingent on any decision rendered by the entity or by any independent medical reviewer.

(C) CERTIFICATION AND RECERTIFICATION PROCESS.—

(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—

(I) under a process that is recognized or approved by the appropriate Secretary; or

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

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

(ii) PROCESS.—The appropriate Secretary shall not recognize or approve a process under clause (i)(I) unless the process applies standards (as promulgated in regulations) that ensure that a qualified external review entity—

(I) will carry out (and has carried out, in the case of recertification) the responsibilities of such an entity in accordance with this section, including meeting applicable deadlines;

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

(III) will maintain (and has maintained, in the case of recertification) appropriate confidentiality with respect to individually identifiable health information obtained in the course of conducting external review activities; and

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

(iii) APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of clause (i)(II), the appropriate Secretary may approve a qualified private standard-setting organization if such Secretary finds that the organization only certifies (or recertifies) external review entities that meet at least the standards required for the certification (or recertification) of external review entities under clause (ii).

(iv) CONSIDERATIONS IN RECERTIFICATIONS.—In conducting recertifications of a qualified external review entity under this paragraph, the appropriate Secretary or organization conducting the recertification shall review compliance of the entity with the requirements for conducting external review activities under this section, including the following:

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

(II) Adherence to applicable deadlines (both by the entity and by independent medical reviewers it refers cases to).

(III) Compliance with limitations on compensation (with respect to both the entity and independent medical reviewers it refers cases to).

(IV) Compliance with applicable independence requirements.

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—A certification or recertification provided under this paragraph shall extend for a period not to exceed 2 years.

(vi) REVOCATION.—A certification or recertification under this paragraph may be revoked by the appropriate Secretary or by the organization providing such certification upon a showing of cause. The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

(viii) SUFFICIENT NUMBER OF ENTITIES.—The appropriate Secretary shall certify and recertify a number of external review entities which is sufficient to ensure the timely and efficient provision of review services.

(D) PROVISION OF INFORMATION.—

(i) IN GENERAL.—A qualified external review entity shall provide to the appropriate Secretary, in such manner and at such times as such Secretary may require, such information (relating to the denials which have been referred to the entity for the conduct of external review under this section) as such Secretary determines appropriate to assure compliance with the independence and other requirements of this section to monitor and assess the quality of its external review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

(ii) INFORMATION TO BE INCLUDED.—The information described in this subclause with respect to an entity is as follows:

(I) The number and types of denials for which a request for review has been received by the entity.

(II) The disposition by the entity of such denials, including the number referred to a independent medical reviewer and the reasons for such dispositions (including the application of exclusions), on a plan or issuer-specific basis and on a health care specialty-specific basis.

(III) The length of time in making determinations with respect to such denials.

(IV) Updated information on the information required to be submitted as a condition of certification with respect to the entity's performance of external review activities.

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

(I) IN GENERAL.—In the case of a qualified external review entity which is certified (or recertified) under this subsection by a qualified private standard-setting organization, at the request of the organization, the entity shall provide the organization with the information provided to the appropriate Secretary under clause (i).

(II) ADDITIONAL INFORMATION.—Nothing in this subparagraph shall be construed as preventing such an organization from requiring additional information as a condition of certification or recertification of an entity.

(iv) USE OF INFORMATION.—Information provided under this subparagraph may be used by the appropriate Secretary and qualified private standard-setting organizations to conduct oversight of qualified external review entities, including recertification of such entities, and shall be made available to the public in an appropriate manner.

(E) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is employed by any such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 601, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

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

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

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

SEC. 105. HEALTH CARE CONSUMER ASSISTANCE FUND.

(a) GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a fund, to be known as the ''Health Care Consumer Assistance Fund'', to be used to award grants to eligible States to carry out consumer assistance activities (including programs established by States prior to the enactment of this Act) designed to provide information, assistance, and referrals to consumers of health insurance products.

(2) STATE ELIGIBILITY.—To be eligible to receive a grant under this subsection a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes—

(A) the manner in which the State will ensure that the health care consumer assistance office (established under paragraph (4)) will educate and assist health care consumers in accessing needed care;

(B) the manner in which the State will coordinate and distinguish the services provided by the health care consumer assistance office with the services provided by Federal, State and local health-related ombudsman, information, protection and advocacy, insurance, and fraud and abuse programs;

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

(D) the manner in which the State will oversee the health care consumer assistance office, its activities, product materials and evaluate program effectiveness;

(E) the manner in which the State will ensure that funds made available under this section will be used to supplement, and not supplant, any other Federal, State, or local funds expended to provide services for programs described under this section and those described in subparagraphs (C) and (D);

(F) the manner in which the State will ensure that health care consumer office personnel have the professional background and training to carry out the activities of the office; and

(G) the manner in which the State will ensure that consumers have direct access to consumer assistance personnel during regular business hours.

(3) AMOUNT OF GRANT.—

(A) IN GENERAL.—From amounts appropriated under subsection (b) for a fiscal year, the Secretary shall award a grant to a State in an amount that bears the same ratio to such amounts as the number of individuals within the State covered under a group health plan or under health insurance coverage offered by a health insurance issuer bears to the total number of individuals so covered in all States (as determined by the

Secretary). Any amounts provided to a State under this subsection that are not used by the State shall be remitted to the Secretary and reallocated in accordance with this subparagraph.

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

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

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

(A) IN GENERAL.—From amounts provided under a grant under this subsection, a State shall, directly or through a contract with an independent, nonprofit entity with demonstrated experience in serving the needs of health care consumers, provide for the establishment and operation of a State health care consumer assistance office.

(B) ELIGIBILITY OF ENTITY.—To be eligible to enter into a contract under subparagraph (A), an entity shall demonstrate that it has the technical, organizational, and professional capacity to deliver the services described in subsection (b) to all public and private health insurance participants, beneficiaries, enrollees, or prospective enrollees.

(C) EXISTING STATE ENTITY.—Nothing in this section shall prevent the funding of an existing health care consumer assistance program that otherwise meets the requirements of this section.

(b) USE OF FUNDS.—

(1) BY STATE.—A State shall use amounts provided under a grant awarded under this section to carry out consumer assistance activities directly or by contract with an independent, non-profit organization. An eligible entity may use some reasonable amount of such grant to ensure the adequate training of personnel carrying out such activities. To receive amounts under this subsection, an eligible entity shall provide consumer assistance services, including—

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

(B) the dissemination of appropriate educational materials on available health insurance products and on how best to access health care and the rights and responsibilities of health care consumers;

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

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

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

(F) the provision of information and assistance, including acting as an authorized representative, regarding internal, external, or administrative grievances or appeals procedures in nonlitigative settings to appeal the denial, termination, or reduction of health care services, or the refusal to pay for such services, under a group health plan or health insurance coverage offered by a health insurance issuer.

(2) CONFIDENTIALITY AND ACCESS TO INFORMATION.—

(A) STATE ENTITY.—With respect to a State that directly establishes a health care consumer assistance office, such office shall establish and implement procedures and protocols in accordance with applicable Federal and State laws.

(B) CONTRACT ENTITY.—With respect to a State that, through contract, establishes a health care consumer assistance office, such office shall establish and implement procedures and protocols, consistent with applicable Federal and State laws, to ensure the confidentiality of all information shared by a participant, beneficiary, enrollee, or their personal representative and their health care providers, group health plans, or health insurance insurers with the office and to ensure that no such information is used by the office, or released or disclosed to State agencies or outside persons or entities without the prior written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) of the individual or personal representative. The office may, consistent with applicable Federal and State confidentiality laws, collect, use or disclose aggregate information that is not individually identifiable (as defined in section 164.501 of title 45, Code of Federal Regulations). The office shall provide a written description of the policies and procedures of the office with respect to the manner in which health information may be used or disclosed to carry out consumer assistance activities. The office shall provide health care providers, group health plans, or health insurance issuers with a written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) to allow the office to obtain medical information relevant to the matter before the office.

(3) AVAILABILITY OF SERVICES.—The health care consumer assistance office of a State shall not discriminate in the provision of information, referrals, and services regardless of the source of the individual'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 plans, or health insurance issuers with the office and to ensure that no information is disclosed to the State agency or office without the written authorization of the individual or their personal representative in accordance with paragraph (2).

(B) CONTRACT ENTITY.—In the case of an entity that enters into a contract with a State under subsection (a)(3), the entity shall provide assurances that the entity has no conflict of interest in carrying out the activities of the office and that the entity is independent of group health plans, health insurance issuers, providers, payers, and regulators of health care.

(5) SUBCONTRACTS.—The health care consumer assistance office of a State may carry out activities and provide services through contracts entered into with 1 or more nonprofit entities so long as the office can demonstrate that all of the requirements of this section are complied with by the office.

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

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

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

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If—

(1) a health insurance issuer providing health insurance coverage in connection with a group health plan offers to enrollees health insurance coverage which provides for coverage of services (including physician pathology services) only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, or

(2) a group health plan offers to participants or beneficiaries health benefits which provide for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the plan to provide such services,

then the issuer or plan shall also offer or arrange to be offered to such enrollees, participants, or beneficiaries (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage or health benefits which provide for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless such enrollees, participants, or beneficiaries are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer or group health plan for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee, participant, or beneficiary unless it is paid by the health plan sponsor or group health plan through agreement with the health insurance issuer.

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

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any

qualified participating health care professional who is available to accept such individual for such care.

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

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

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

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider 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 section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

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

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 114. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

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

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

(A) to require the coverage under a group health plan or health insurance coverage of benefits 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) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a nonparticipating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan and a health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition.

(B) ONGOING SPECIAL CONDITION DEFINED.—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 specialty 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 primary 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

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

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

(d) SPECIALIST DEFINED.—For purposes of this section, the term ''specialist'' means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, and a health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan and a health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access

described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

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

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

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

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

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

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

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

SEC. 117. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in paragraph (e)(4)), or

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

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

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

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

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

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

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

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

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

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

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

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

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

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

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

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

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

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

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

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

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

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

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' or ''provider'' means—

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

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

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

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section 114(b)(2)(B)).

(4) TERMINATED.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

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

(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary;

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

(3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

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

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

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

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

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

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

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

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

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

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

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

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation—

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

(i) the National Institutes of Health;

(ii) a cooperative group or center of the National Institutes of Health, including a qualified nongovernmental research entity to which the National Cancer Institute has awarded a center support grant;

(iii) either of the following if the conditions described in paragraph (2) are met—

(I) the Department of Veterans Affairs;

(II) the Department of Defense; or

(B) approved by the Food and Drug Administration.

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

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

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

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to 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.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

(A) a mastectomy;

(B) a lumpectomy; or

(C) a lymph node dissection for the treatment of breast cancer.

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

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage, may not modify the terms and conditions of coverage based on the determination by a participant, beneficiary, or enrollee to request less than the minimum coverage required under subsection (a).

(c) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan or coverage with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan or issuer.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(d) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage, may not—

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant, beneficiary, or enrollee in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

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

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) REQUIREMENT.—

(1) DISCLOSURE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure to participants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year; and

(iii) of information relating to any material reduction to the benefits or information described in such subsection or subsection (c), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect.

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

(i) jointly to each participant, beneficiary, and enrollee who reside at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

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

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

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

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

(C) any specific exclusions or express limitations of benefits described in section 104(d)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

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

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

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

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

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

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

(5) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients.

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

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

(8) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(9) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 112(b)(2) and the right to timely access to specialists care under section 114 if such section applies.

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

(11) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(12) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(13) CLAIMS AND APPEALS.—A description of the plan or issuer's rules and procedures pertaining to claims and appeals, a description of the rights (including deadlines for exercising rights) of participants, beneficiaries, and enrollees under subtitle A in obtaining covered benefits, filing a claim for benefits, and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(14) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(15) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

(16) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants, beneficiaries, and enrollees with communication disabilities and a description of how to access these items or services.

(17) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants, beneficiaries, and enrollees.

(18) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (17)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

(19) AVAILABILITY OF ADDITIONAL INFORMATION.—A statement that the information described in subsection (c), and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request.

(20) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each such decisionmaker.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee shall include for each option available under a group health plan or health insurance coverage the following:

(1) STATUS OF PROVIDERS.—The State licensure status of the plan or issuer's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

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

(3) PRESCRIPTION DRUGS.—Information about whether a specific prescription medication is included in the formulary of the plan or issuer, if the plan or issuer uses a defined formulary.

(4) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

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

(d) MANNER OF DISCLOSURE.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(e) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; and

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

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

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

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan, and a health insurance issuer with respect to health insurance coverage, shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

(1) as requiring the coverage under a group health plan or health insurance coverage of a particular benefit or service or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

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

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

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

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

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner that is no less protective than the provisions of section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2)).

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

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

(1) IN GENERAL.—A group health plan and a health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

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

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

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

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

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

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

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

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

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

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

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

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

(2) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

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

(10) TERMS AND CONDITIONS.—The term ''terms and conditions'' includes, with respect to a group health plan or health insurance coverage, requirements imposed under this title with respect to the plan or coverage.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

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

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

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this Act (except in the case of other substantially compliant requirements), in applying the requirements of this title under section 2707 and 2753 (as applicable) of the Public Health Service Act (as added by title II), subject to subsection (a)(2)—

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

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' 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 with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

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

(3) APPROVAL.—

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

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

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

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

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved with respect to the patient protection involved.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

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

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

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

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

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this Act become effective, as provided for in section 601, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

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

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

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

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

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

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

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

(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

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

(C) allows access to any provider that is lawfully authorized to provide the covered services and that agrees to accept the terms and conditions of payment established under the plan or by the issuer; and

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

SEC. 154. TREATMENT OF EXCEPTED BENEFITS.

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

(b) COVERAGE OF CERTAIN LIMITED SCOPE PLANS.—Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act, section 714 of the Employee Retirement Income Security Act of 1974, and section 9813 of the Internal Revenue Code of 1986, the following sections shall be deemed not to apply:

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

(2) Section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974.

(3) Section 9832(c)(2)(A) of the Internal Revenue Code of 1986.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services, Labor, and the Treasury shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

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

SEC. 157. PRESERVATION OF PROTECTIONS.

(a) IN GENERAL.—The rights under this Act (including the right to maintain a civil action and any other rights under the amendments made by this Act) may not be waived, deferred, or lost pursuant to any agreement not authorized under this Act.

(b) EXCEPTION.—Subsection (a) shall not apply to an agreement providing for arbitration or participation in any other nonjudicial procedure to resolve a dispute if the agreement is entered into knowingly and voluntarily by the parties involved after the dispute has arisen or is pursuant to the terms of a collective bargaining agreement. Nothing in this subsection shall be construed to permit the waiver of the requirements of sections 103 and 104 (relating to internal and external review).

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.

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

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

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

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act with respect to individual health

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

SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

''SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

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

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO FEDERAL HEALTH INSURANCE PROGRAMS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that enrollees in Federal health insurance programs should have the same rights and privileges as those afforded under title I and under the amendments made by title IV to participants and beneficiaries under group health plans.

(b) CONFORMING FEDERAL HEALTH INSURANCE PROGRAMS.—It is the sense of Congress that the President should require, by executive order, the Federal official with authority over each Federal health insurance program, to the extent feasible, to take such steps as are necessary to implement the rights and privileges described in subsection (a) with respect to such program.

(c) GAO REPORT ON ADDITIONAL STEPS REQUIRED.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on statutory changes that are required to implement such rights and privileges in a manner that is consistent with the missions of the Federal health insurance programs and that avoids unnecessary duplication or disruption of such programs.

(d) FEDERAL HEALTH INSURANCE PROGRAM.—In this section, the term ''Federal health insurance program'' means a Federal program that provides creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act) and includes a health program of the Department of Veterans Affairs.

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.

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

''SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Patient Protection Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Patient Protection Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 111 (relating to consumer choice option).

''(B) Section 112 (relating to choice of health care professional).

''(C) Section 113 (relating to access to emergency care).

''(D) Section 114 (relating to timely access to specialists).

''(E) Section 115 (relating to patient access to obstetrical and gynecological care).

''(F) Section 116 (relating to access to pediatric care).

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

''(H) Section 118 (relating to access to needed prescription drugs).

''(I) Section 119 (relating to coverage for individuals participating in approved clinical trials).

''(J) Section 120 (relating to required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations).

''(K) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121 of the Bipartisan Patient Protection Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) INTERNAL APPEALS.—With respect to the internal appeals process required to be established under section 103 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 104 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections of the Bipartisan Patient Protection Act, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) TREATMENT OF SUBSTANTIALLY COMPLIANT STATE LAWS.—For purposes of applying this subsection in connection with health insurance coverage, any reference in this subsection to a requirement in a section or other provision in the Bipartisan Patient Protection Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 152(c) of such Act) with the requirement in such section or other provisions.

''(8) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Patient Protection Act, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Patient Protection Act may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title. In order to reduce duplication and clarify the rights of participants and beneficiaries with respect to information that is required to be provided, such regulations shall coordinate the information disclosure requirements under section 121 of the Bipartisan Patient Protection Act with the reporting and disclosure requirements imposed under part 1, so long as such coordination does not result in any reduction in the information that would otherwise be provided to participants and beneficiaries.''.

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

''(b) In the case of a group health plan (as defined in section 733), compliance with the requirements of subtitle A of title I of the Bipartisan Patient Protection Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial, shall be deemed compliance with subsection (a) with respect to such claims denial.''.

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

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

''SEC. 714. PATIENT PROTECTION STANDARDS.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 402. AVAILABILITY OF CIVIL REMEDIES.

(a) AVAILABILITY OF FEDERAL CIVIL REMEDIES IN CASES NOT INVOLVING MEDICALLY REVIEWABLE DECISIONS.—

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

''(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

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

''(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer, or plan sponsor, upon consideration of a claim for benefits of a participant or beneficiary under section 102 of the Bipartisan Patient Protection Act (relating to procedures for initial claims for benefits and prior authorization determinations) or upon review of a denial of such a claim under section 103 of such Act (relating to internal appeal of a denial of a claim for benefits), fails to exercise ordinary care in making a decision—

''(i) regarding whether an item or service is covered under the terms and conditions of the plan or coverage,

''(ii) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage), or

''(iii) as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage, and

''(B) such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary,

such plan, plan sponsor, or issuer shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages (but not exemplary or punitive damages) in connection with such personal injury or death.

''(2) CAUSE OF ACTION MUST NOT INVOLVE MEDICALLY REVIEWABLE DECISION.—

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

''(B) MEDICALLY REVIEWABLE DECISION.—For purposes of this subsection, the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act (relating to medically reviewable decisions).

''(3) LIMITATION REGARDING CERTAIN TYPES OF ACTIONS SAVED FROM PREEMPTION OF STATE LAW.—A cause of action is not established under paragraph (1)(A) in connection with a failure described in paragraph (1)(A) to the extent that a cause of action under State law (as defined in section 514(c)) for such failure would not be preempted under section 514.

''(4) DEFINITIONS AND RELATED RULES.—For purposes of this subsection.—

''(A) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

''(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(C) CLAIM FOR BENEFITS; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' have the meanings provided such terms in section 102(e) of the Bipartisan Patient Protection Act.

''(D) TERMS AND CONDITIONS.—The term 'terms and conditions' includes, with respect to a group health plan or health insurance coverage, requirements imposed under title I of the Bipartisan Patient Protection Act.

''(E) TREATMENT OF EXCEPTED BENEFITS.—Under section 154(a) of the Bipartisan Patient Protection Act, the provisions of this subsection and subsection (a)(1)(C) do not apply to certain excepted benefits.

''(5) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1)(A) does not authorize a cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment).

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) under paragraph (1)(A), to the extent there was direct participation by the employer or other plan sponsor (or employee) in the decision of the plan under section 102 of the Bipartisan Patient Protection Act upon consideration of a claim for benefits or under section 103 of such Act upon review of a denial of a claim for benefits.

''(C) DIRECT PARTICIPATION.—

''(i) IN GENERAL.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in paragraph (1)(A), the actual making of such decision or the actual exercise of control in making such decision.

''(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 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

''(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

''(iii) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

''(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

''(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions 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 responsibility) that is self-insured and self-administered.

''(6) EXCLUSION OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.—

''(A) IN GENERAL.—No treating physician or other treating health care professional of the participant or beneficiary, and no person acting under the direction of such a physician or health care professional, shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(B) DEFINITIONS.—For purposes of subparagraph (A)—

''(i) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(ii) NON-MEDICALLY REVIEWABLE DUTY.—The term 'non-medically reviewable duty' means a duty the discharge of which does not include the making of a medically reviewable decision.

''(7) EXCLUSION OF HOSPITALS.—No treating hospital of the participant or beneficiary shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty (as defined in paragraph (6)(B)(ii)) of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(8) RULE OF CONSTRUCTION RELATING TO EXCLUSION FROM LIABILITY OF PHYSICIANS,

HEALTH CARE PROFESSIONALS, AND HOSPITALS.—Nothing in paragraph (6) or (7) shall be construed to limit the liability (whether direct or vicarious) of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS 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 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 Bipartisan Patient Protection Act 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 ⅓ 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 DISTRICT COURT.—The last Federal district court in which the action was pending upon the final disposition, including all appeals, of the action shall have jurisdiction to review the attorney's fee to ensure that the fee is a reasonable one.

''(12) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after 3 years after the later of—

''(A) the date on which the plaintiff first knew, or reasonably should have known, of the personal injury or death resulting from the failure described in paragraph (1), or

''(B) the date as of which the requirements of paragraph (9) are first met.

''(13) TOLLING PROVISION.—The statute of limitations for any cause of action arising under State law relating to a denial of a claim for benefits that is the subject of an action brought in Federal court under this subsection shall be tolled until such time as the Federal court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the Federal court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

''(14) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

''(15) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not include making decisions on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(16) EXCLUSION OF HEALTH INSURANCE AGENTS.—Paragraph (1) does not apply with respect to a person whose sole involvement with the group health plan is providing advice or administrative services to the employer or other plan sponsor relating to the selection of health insurance coverage offered in connection with the plan.

''(17) NO EFFECT ON STATE LAW.—No provision of State law (as defined in section 514(c)(1)) shall be treated as superseded or otherwise altered, amended, modified, invalidated, or impaired by reason of the provisions of subsection (a)(1)(C) and this subsection.

''(18) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Notwithstanding the direct participation (as defined in paragraph (5)(C)(i)) of an employer or plan sponsor, in any case in which there is (or is deemed under subparagraph (B) to be) a designated decisionmaker that meets the requirements of subsection (o)(1) for an employer or other plan sponsor—

''(i) all liability of such employer or plan sponsor involved (and any employee of such employer or sponsor acting within the scope of employment) under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker, and

''(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or sponsor (or employee) in the action and may not raise any defense that the employer or sponsor (or employee) could not raise if such a decisionmaker were not so deemed.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (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.).

''(19) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures; or

''(ii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(20) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(o) REQUIREMENTS FOR DESIGNATED DECISIONMAKERS OF GROUP HEALTH PLANS.—

''(1) IN GENERAL.—For purposes of subsection (n)(18) and section 514(d)(9), a designated decisionmaker meets the requirements of this paragraph with respect to any participant or beneficiary if—

''(A) such designation is in such form as may be prescribed in regulations of the Secretary,

''(B) the designated decisionmaker—

''(i) meets the requirements of paragraph (2),

''(ii) assumes unconditionally all liability of the employer or plan sponsor involved (and any employee of such employer or sponsor acting within the scope of employment) either arising under subsection (n) or arising in a cause of action permitted under section 514(d) in connection with actions (and failures to act) of the employer or plan sponsor (or employee) occurring during the period in which the designation under subsection (n)(18) or section 514(d)(9) is in effect relating to such participant and beneficiary,

''(iii) agrees to be substituted for the employer or plan sponsor (or employee) in the action and not to raise any defense with respect to such liability that the employer or plan sponsor (or employee) may not raise, and

''(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant 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 Bipartisan Patient Protection Act.

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 sponsor or named fiduciary and to the Secretary upon designation under subsection (n)(18)(B) or section 517(d)(9)(B) and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

''(B) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a single health insurance issue, such issuer is the only entity that may be qualified under this paragraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

''(3) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of paragraph (2)(A), the requirements relating to the financial obligation of an entity for liability shall include—

''(A) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this part; or

''(B) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this part.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this paragraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

''(4) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d) may not be designated as a designated decisionmaker under this subsection with respect to such participant or beneficiary.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking ''or'' at the end of subparagraph (A);

(B) in subparagraph (B), by striking ''plan;'' and inserting ''plan, or''; and

(C) by adding at the end the following new subparagraph:

''(C) for the relief provided for in subsection (n) of this section.''.

(b) RULES RELATING TO ERISA PREEMPTION.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following new subsections:

''(d) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION UNDER STATE LAW INVOLVING MEDICALLY REVIEWABLE DECISION.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to supersede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) against the plan, the plan sponsor, any health insurance issuer offering health insurance coverage in connection with the plan, or any managed care entity in connection with the plan to recover damages resulting from personal injury or for wrongful death if such cause of action arises by reason of a medically reviewable decision.

''(B) MEDICALLY REVIEWABLE DECISION.—For purposes of subparagraph (A), the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act (relating to medically reviewable decisions).

''(C) LIMITATION ON PUNITIVE DAMAGES.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), with respect to a cause of action described in subparagraph (A) brought with respect to a participant or beneficiary, State law is superseded insofar as it provides any punitive, exemplary, or similar damages if, as of the time of the personal injury or death, all the requirements of the following sections of the Bipartisan Patient Protection Act were satisfied with respect to the participant or beneficiary:

''(I) Section 102 (relating to procedures for initial claims for benefits and prior authorization determinations).

''(II) Section 103 of such Act (relating to internal appeals of claims denials).

''(III) Section 104 of such Act (relating to independent external appeals procedures).

''(ii) EXCEPTION FOR CERTAIN ACTIONS FOR WRONGFUL DEATH.—Clause (i) shall not apply with respect to an action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such an action which are only punitive or exemplary in nature.

''(iii) EXCEPTION FOR WILLFUL OR WANTON DISREGARD FOR THE RIGHTS OR SAFETY OF OTHERS.—Clause (i) shall not apply with respect to any cause of action described in subparagraph (A) if, in such action, the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with willful or wanton disregard for the rights or safety of others was a proximate cause of the personal injury or wrongful death that is the subject of the action.

''(2) DEFINITIONS AND RELATED RULES.—For purposes of this subsection and subsection (e)—

''(A) TREATMENT OF EXCEPTED BENEFITS.—Under section 154(a) of the Bipartisan Patient Protection Act, the provisions of this subsection do not apply to certain excepted benefits.

''(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(C) CLAIM FOR BENEFIT; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' shall have the meaning provided such terms under section 102(e) of the Bipartisan Patient Protection Act.

''(D) MANAGED CARE ENTITY.—

''(i) IN GENERAL.—The term 'managed care entity' means, in connection with a group health plan and subject to clause (ii), any entity that is involved in determining the manner in which or the extent to which items or services (or reimbursement therefor) are to be provided as benefits under the plan.

''(ii) TREATMENT OF TREATING PHYSICIANS, OTHER TREATING HEALTH CARE PROFESSIONALS, AND TREATING HOSPITALS.—Such term does not include a treating physician or other treating health care professional (as defined in section 502(n)(6)(B)(i)) of the participant or beneficiary and also does not include a treating hospital insofar as it is acting solely in the capacity of providing treatment or care to the participant or beneficiary. Nothing in the preceding sentence shall be construed to preempt vicarious liability of any plan, plan sponsor, health insurance issuer, or managed care entity.

''(3) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1) does not apply with respect to—

''(i) any cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

''(ii) a right of recovery, indemnity, or contribution by a person against an employer or other plan sponsor (or such an employee) for

damages assessed against the person pursuant to a cause of action to which paragraph (1) applies.

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), paragraph (1) applies with respect to any cause of action that is brought by a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment) if such cause of action arises by reason of a medically reviewable decision, to the extent that there was direct participation by the employer or other plan sponsor (or employee) in the decision.

''(C) DIRECT PARTICIPATION.—

''(i) DIRECT PARTICIPATION IN DECISIONS.—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 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

''(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

''(iv) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

''(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

''(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions of the plan for that or any other participant or beneficiary (or any group of participants or beneficiaries).

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—Except as provided in subparagraph (D), a cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102, 103, and 104 of the Bipartisan Patient Protection Act (if applicable) have been exhausted.

''(B) LATE MANIFESTATION OF INJURY.—

''(i) IN GENERAL.—A participant or beneficiary shall not be precluded from pursuing a review under section 104 of the Bipartisan Patient Protection Act regarding an injury that such participant or beneficiary has experienced if the external review entity first determines that the injury of such participant or beneficiary is a late manifestation of an earlier injury.

''(ii) DEFINITION.—In this subparagraph, the term 'late manifestation of an earlier injury' means an injury sustained by the participant or beneficiary which was not known, and should not have been known, by such participant or beneficiary by the latest date that the requirements of subparagraph (A) should have been met regarding the claim for benefits which was denied.

''(C) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(D) FAILURE TO REVIEW.—

''(i) IN GENERAL.—If the external review entity fails to make a determination within the time required under section 104(e)(1)(A)(i), a participant or beneficiary may bring an action under section 514(d) after 10 additional days after the date on which such time period has expired and the filing of such action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to 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), a participant or beneficiary may bring an action under this subsection 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 section 104(e)(1)(A)(ii).

''(E) RECEIPT OF BENEFITS DURING APPEALS 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 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.

''(F) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

''(5) TOLLING PROVISION.—The statute of limitations for any cause of action arising under section 502(n) relating to a denial of a claim for benefits that is the subject of an action brought in State court shall be tolled until such time as the State court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the State court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

''(6) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not include making decisions on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) saving from preemption a cause of action under State law for the failure to provide a benefit for an item or service which is specifically excluded under the group health plan involved, except to the extent that—

''(i) the application or interpretation of the exclusion involves a determination described in section 104(d)(2) of the Bipartisan Patient Protection Act, or

''(ii) the provision of the benefit for the item or service is required under Federal law or under applicable State law consistent with subsection (b)(2)(B);

''(B) preempting a State law which requires an affidavit or certificate of merit in a civil action;

''(C) affecting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A); or

''(D) affecting a cause of action under State law other than a cause of action described in paragraph (1)(A).

''(8) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action described in paragraph (1)(A).

''(9) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to any cause of action described in paragraph (1)(A) under State law insofar as such cause of action provides for liability with respect to a participant or beneficiary of an employer or plan sponsor (or an employee of such employer or sponsor acting within the scope of employment), if with respect to the employer or plan sponsor there is (or is deemed under subparagraph (B) to be) a designated decisionmaker that meets the requirements of section 502(o)(1) with respect to such participant or beneficiary. Such paragraph (1) shall apply with respect to any cause of action described in paragraph (1)(A) under State law against the designated decisionmaker of such employer or other plan sponsor with respect to the participant or beneficiary.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (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, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(11) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(12) CHOICE OF LAW.—A cause of action brought under paragraph (1) shall be governed by the law (including choice of law rules) of the State in which the plaintiff resides.

''(13) 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 under paragraph (1) shall not exceed ⅓ 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 under paragraph (1) 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 (whether the liability is direct or vicarious) based upon such a State law,

''(2) superseding any State law permitted under section 152(b)(1)(A) of the Bipartisan Patient Protection Act, or

''(3) affecting any applicable State law with respect to limitations on monetary damages.

''(f) NO RIGHT OF ACTION FOR RECOVERY, INDEMNITY, OR CONTRIBUTION BY ISSUERS AGAINST TREATING HEALTH CARE PROFESSIONALS AND TREATING HOSPITALS.—In the case of any care provided, or any treatment decision made, by the treating health care professional or the treating hospital of a participant or beneficiary under a group health plan which consists of medical care provided under such plan, any cause of action under State law against the treating health care professional or the treating hospital by the plan or a health insurance issuer providing health insurance coverage in connection with the plan for recovery, indemnity, or contribution in connection with such care (or any medically reviewable decision made in connection with such care) or such treatment decision is superseded.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the applicable effective under section 601.

SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402, is further amended by adding at the end the following:

''(p) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.''.

SEC. 404. LIMITATIONS ON ACTIONS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 402(a)) is amended further by adding at the end the following new subsection:

''(q) LIMITATIONS ON ACTIONS RELATING TO GROUP HEALTH PLANS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 101, subtitle B, or subtitle D of title I of the Bipartisan Patient Protection Act (as incorporated under section 714).

''(2) CERTAIN ACTIONS ALLOWABLE.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 101, 113, 114, 115, 116, 117, 118(a)(3), 119, or 120 of the Bipartisan Patient Protection Act (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) OTHER PROVISIONS UNAFFECTED.—Nothing in this subsection shall be construed as affecting subsections (a)(1)(C) and (n) or section 514(d).

''(4) ENFORCEMENT BY SECRETARY UNAFFECTED.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

SEC. 405. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following new section:

''SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

SEC. 406. SENSE OF THE SENATE CONCERNING THE IMPORTANCE OF CERTAIN UNPAID SERVICES.

It is the sense of the Senate that the court should consider the loss of a nonwage earning spouse or parent as an economic loss for the purposes of this section. Furthermore, the court should define the compensation for the loss not as minimum services, but, rather, in terms that fully compensate for the true and whole replacement cost to the family.

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 Bipartisan Patient Protection Act (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.''.

SEC. 502. CONFORMING ENFORCEMENT FOR WOMEN'S HEALTH AND CANCER RIGHTS.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 501, is further amended—

(1) in the table of sections, by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Standard relating to women's health and cancer rights.'';

and

(2) by inserting after section 9813 the following:

"SEC. 9814. STANDARD RELATING TO WOMEN'S HEALTH AND CANCER RIGHTS.

''The provisions of section 713 of the Employee Retirement Income Security Act of 1974 (as in effect as of the date of the enactment of this section) shall apply to group health plans as if included in this subchapter.''.

Subtitle B—Health Care Coverage Access Tax Incentives

SEC. 511. EXPANDED AVAILABILITY OF ARCHER MSAS.

(a) EXTENSION OF PROGRAM.—Paragraphs (2) and (3)(B) of section 220(i) of the Internal Revenue Code of 1986 (defining cut-off year) are each amended by striking ''2002'' each place it appears and inserting ''2004''.

(b) INCREASE IN NUMBER OF PERMITTED ACCOUNT PARTICIPANTS.—

(1) IN GENERAL.—Subsection (j) of section 220 of such Code is amended by redesignating paragraphs (3), (4), and (5) as paragraphs (4), (5), and (6) and by inserting after paragraph (2) the following new paragraph:

''(3) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR YEARS AFTER 2001.—

''(A) IN GENERAL.—The numerical limitation for any year after 2001 is exceeded if the sum of—

''(i) the number of Archer MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

''(ii) the Secretary's estimate (determined on the basis of the returns described in clause (i)) of the number of Archer MSA returns for such taxable years which will be filed after such date, exceeds 1,000,000. For purposes of the preceding sentence, the term 'Archer MSA return' means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

''(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for any year after 2001 is also exceeded if the sum of—

''(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

''(ii) the product of 2.5 and the number of medical savings accounts established during the portion of such year preceding July 1 (based on the reports required under paragraph (5)) for taxable years beginning in such year,

exceeds 1,000,000''.

(2) CONFORMING AMENDMENTS.—

(A) Clause (ii) of section 220(j)(2)(B) of such Code is amended by striking ''paragraph (4)'' and inserting ''paragraph (5)''.

(B) Subparagraph (A) of section 220(j)(4) of such Code is amended by striking ''and 2001'' and inserting ''2001, 2002, and 2003''.

(c) INCREASE IN SIZE OF ELIGIBLE EMPLOYERS.—Subparagraph (A) of section 220(c)(4) of such Code is amended by striking ''50 or fewer employees'' and inserting ''100 or fewer employees''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(e) GAO STUDY.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the impact of Archer MSAs on the cost of conventional insurance (especially in those areas where there are higher numbers of such accounts) and on adverse selection and health care costs.

SEC. 512. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 513. CREDIT FOR HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following:

"SEC. 45G. SMALL BUSINESS HEALTH INSURANCE EXPENSES.

''(a) GENERAL RULE.—For purposes of section 38, in the case of a small employer, the health insurance credit determined under this section for the taxable year is an amount equal to the applicable percentage of the expenses paid by the taxpayer during the taxable year for health insurance coverage for such year provided under a new health plan for employees of such employer.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage is—

''(1) in the case of insurance purchased as a member of a qualified health benefit purchasing coalition (as defined in section 9841), 30 percent, and

''(2) in the case of insurance not described in paragraph (1), 20 percent.

''(c) LIMITATIONS.—

''(1) PER EMPLOYEE DOLLAR LIMITATION.—The amount of expenses taken into account under subsection (a) with respect to any employee for any taxable year shall not exceed—

''(A) $2,000 in the case of self-only coverage, and

''(B) $5,000 in the case of family coverage.

In the case of an employee who is covered by a new health plan of the employer for only a portion of such taxable year, the limitation under the preceding sentence shall be an amount which bears the same ratio to such limitation (determined without regard to this sentence) as such portion bears to the entire taxable year.

''(2) PERIOD OF COVERAGE.—Expenses may be taken into account under subsection (a) only with respect to coverage for the 4-year period beginning on the date the employer establishes a new health plan.

''(d) DEFINITIONS.—For purposes of this section—

''(1) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1).

''(2) NEW HEALTH PLAN.—

''(A) IN GENERAL.—The term 'new health plan' means any arrangement of the employer which provides health insurance coverage to employees if—

''(i) such employer (and any predecessor employer) did not establish or maintain such arrangement (or any similar arrangement) at any time during the 2 taxable years ending prior to the taxable year in which the credit under this section is first allowed, and

''(ii) such arrangement provides health insurance coverage to at least 70 percent of the qualified employees of such employer.

''(B) QUALIFIED EMPLOYEE.—

''(i) IN GENERAL.—The term 'qualified employee' means any employee of an employer if the annual rate of such employee's compensation (as defined in section 414(s)) exceeds $10,000.

''(ii) TREATMENT OF CERTAIN EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

''(3) SMALL EMPLOYER.—The term 'small employer' has the meaning given to such term by section 4980D(d)(2); except that only qualified employees shall be taken into account.

''(e) SPECIAL RULES.—

''(1) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

''(2) AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred pursuant to a salary reduction arrangement shall be taken into account under subsection (a).

''(f) TERMINATION.—This section shall not apply to expenses paid or incurred by an employer with respect to any arrangement established on or after January 1, 2010.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of such Code (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting '', plus'', and by adding at the end the following:

''(16) in the case of a small employer (as defined in section 45G(d)(3)), the health insurance credit determined under section 45G(a).''.

(c) NO CARRYBACKS.—Subsection (d) of section 39 of such Code (relating to carryback and carryforward of unused credits) is amended by adding at the end the following:

''(11) NO CARRYBACK OF SECTION 45G CREDIT BEFORE EFFECTIVE DATE.—No portion of the unused business credit for any taxable year which is attributable to the employee health insurance expenses credit determined under section 45G may be carried back to a taxable year ending before the date of the enactment of section 45G.''.

(d) DENIAL OF DOUBLE BENEFIT.—Section 280C of such Code is amended by adding at the end the following new subsection:

''(d) CREDIT FOR SMALL BUSINESS HEALTH INSURANCE EXPENSES.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the expenses (otherwise allowable as a deduction) taken into account in determining the credit under section 45G for the taxable year which is equal to the amount of the credit determined for such taxable year under section 45G(a).

''(2) CONTROLLED GROUPS.—Persons treated as a single employer under subsection (a) or (b) of section 52 shall be treated as 1 person for purposes of this section.''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding at the end the following:

''Sec. 45G. Small business health insurance expenses.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2001, for arrangements established after the date of the enactment of this Act.

SEC. 514. CERTAIN GRANTS BY PRIVATE FOUNDATIONS TO QUALIFIED HEALTH BENEFIT PURCHASING COALITIONS.

(a) IN GENERAL.—Section 4942 of the Internal Revenue Code of 1986 (relating to taxes on failure to distribute income) is amended by adding at the end the following:

''(k) CERTAIN QUALIFIED HEALTH BENEFIT PURCHASING COALITION DISTRIBUTIONS.—

''(1) IN GENERAL.—For purposes of subsection (g), sections 170, 501, 507, 509, and 2522, and this chapter, a qualified health benefit purchasing coalition distribution by a private foundation shall be considered to be a distribution for a charitable purpose.

''(2) QUALIFIED HEALTH BENEFIT PURCHASING COALITION DISTRIBUTION.—For purposes of paragraph (1)—

''(A) IN GENERAL.—The term 'qualified health benefit purchasing coalition distribution' means any amount paid or incurred by a private foundation to or on behalf of a qualified health benefit purchasing coalition (as defined in section 9841) for purposes of payment or reimbursement of amounts paid or incurred in connection with the establishment and maintenance of such coalition.

''(B) EXCLUSIONS.—Such term shall not include any amount used by a qualified health benefit purchasing coalition (as so defined)—

''(i) for the purchase of real property,

''(ii) as payment to, or for the benefit of, members (or employees or affiliates of such members) of such coalition, or

''(iii) for any expense paid or incurred more than 48 months after the date of establishment of such coalition.

''(3) TERMINATION.—This subsection shall not apply—

''(A) to qualified health benefit purchasing coalition distributions paid or incurred after December 31, 2009, and

''(B) with respect to start-up costs of a coalition which are paid or incurred after December 31, 2010.''.

(b) QUALIFIED HEALTH BENEFIT PURCHASING COALITION.—

(1) IN GENERAL.—Chapter 100 of such Code (relating to group health plan requirements) is amended by adding at the end the following new subchapter:

''Subchapter D—Qualified Health Benefit Purchasing Coalition

''Sec. 9841. Qualified health benefit purchasing coalition.

''SEC. 9841. QUALIFIED HEALTH BENEFIT PURCHASING COALITION.

''(a) IN GENERAL.—A qualified health benefit purchasing coalition is a private not-for-profit corporation which—

''(1) sells health insurance through State licensed health insurance issuers in the State in which the employers to which such coalition is providing insurance are located, and

''(2) establishes to the Secretary, under State certification procedures or other procedures as the Secretary may provide by regulation, that such coalition meets the requirements of this section.

''(b) BOARD OF DIRECTORS.—

''(1) IN GENERAL.—Each purchasing coalition under this section shall be governed by a Board of Directors.

''(2) ELECTION.—The Secretary shall establish procedures governing election of such Board.

''(3) MEMBERSHIP.—The Board of Directors shall—

''(A) be composed of representatives of the members of the coalition, in equal number, including small employers and employee representatives of such employers, but

''(B) not include other interested parties, such as service providers, health insurers, or insurance agents or brokers which may have a conflict of interest with the purposes of the coalition.

''(c) MEMBERSHIP OF COALITION.—

''(1) IN GENERAL.—A purchasing coalition shall accept all small employers residing within the area served by the coalition as members if such employers request such membership.

''(2) OTHER MEMBERS.—The coalition, at the discretion of its Board of Directors, may be open to individuals and large employers.

''(3) VOTING.—Members of a purchasing coalition shall have voting rights consistent with the rules established by the State.

''(d) DUTIES OF PURCHASING COALITIONS.—Each purchasing coalition shall—

''(1) enter into agreements with small employers (and, at the discretion of its Board, with individuals and other employers) to provide health insurance benefits to employees and retirees of such employers,

''(2) where feasible, enter into agreements with 3 or more unaffiliated, qualified licensed health plans, to offer benefits to members,

''(3) offer to members at least 1 open enrollment period of at least 30 days per calendar year,

''(4) serve a significant geographical area and market to all eligible members in that area, and

''(5) carry out other functions provided for under this section.

''(e) LIMITATION ON ACTIVITIES.—A purchasing coalition shall not—

''(1) perform any activity (including certification or enforcement) relating to compliance or licensing of health plans,

''(2) assume insurance or financial risk in relation to any health plan, or

''(3) perform other activities identified by the State as being inconsistent with the performance of its duties under this section.

''(f) ADDITIONAL REQUIREMENTS FOR PURCHASING COALITIONS.—As provided by the Secretary in regulations, a purchasing coalition shall be subject to requirements similar to the requirements of a group health plan under this chapter.

''(g) RELATION TO OTHER LAWS.—

''(1) PREEMPTION OF STATE FICTITIOUS GROUP LAWS.—Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for health insurance coverage are preempted to the extent such requirements impede the establishment and operation of qualified health benefit purchasing coalitions.

''(2) ALLOWING SAVINGS TO BE PASSED THROUGH.—Any State law that prohibits health insurance issuers from reducing premiums on health insurance coverage sold through a qualified health benefit purchasing coalition to reflect administrative savings is preempted. This paragraph shall not be construed to preempt State laws that impose restrictions on premiums based on health status, claims history, industry, age, gender, or other underwriting factors.

''(3) NO WAIVER OF HIPAA REQUIREMENTS.—Nothing in this section shall be construed to change the obligation of health insurance issuers to comply with the requirements of title XXVII of the Public Health Service Act with respect to health insurance coverage offered to small employers in the small group market through a qualified health benefit purchasing coalition.

''(h) DEFINITION OF SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'small employer' means, with respect to any calendar year, any employer if such employer employed an average of at least 2 and not more than 50 qualified employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

''(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under paragraph (1) shall be based on the average number of qualified employees that it is reasonably expected such employer will employ on business days in the current calendar year.''.

(2) CONFORMING AMENDMENT.—The table of subchapters for chapter 100 of such Code is amended by adding at the end the following item:

''Subchapter D. Qualified health benefit purchasing coalition.''.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2001.

SEC. 515. STATE GRANT PROGRAM FOR MARKET INNOVATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program (in this section referred to as the ''program'') to award demonstration grants under this section to States to allow States to demonstrate the effectiveness of innovative ways to increase access to health insurance through market reforms and other innovative means. Such innovative means may include (and are not limited to) any of the following:

(1) Alternative group purchasing or pooling arrangements, such as purchasing cooperatives for small businesses, reinsurance pools, or high risk pools.

(2) Individual or small group market reforms.

(3) Consumer education and outreach.

(4) Subsidies to individuals, employers, or both, in obtaining health insurance.

(b) SCOPE; DURATION.—The program shall be limited to not more than 10 States and to a total period of 5 years, beginning on the date the first demonstration grant is made.

(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary may not provide for a demonstration grant to a State under the program unless the Secretary finds that under the proposed demonstration grant—

(A) the State will provide for demonstrated increase of access for some portion of the existing uninsured population through a market innovation (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 population, expected cost, and the continuation after the completion of the demonstration grant period; and

(C) the Secretary determines that the demonstration grant will be used consistent with this section.

(3) FOCUS.—A demonstration grant proposal under section need not cover all uninsured individuals in a State or all health care benefits with respect to such individuals.

(d) EVALUATION.—The Secretary shall enter into a contract with an appropriate entity outside the Department of Health and Human Services to conduct an overall evaluation of the program at the end of the program period. Such evaluation shall include an analysis of improvements in access, costs, quality of care, or choice of coverage, under different demonstration grants.

(e) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Notwithstanding the previous provisions of this section, under the program the Secretary may provide for a portion of the amounts appropriated under subsection (f) (not to exceed $5,000,000) to be made available to any State for initial planning grants to permit States to develop demonstration grant proposals under the previous provisions of this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $100,000,000 for each fiscal year to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) STATE DEFINED.—For purposes of this section, the term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

TITLE VI—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 601. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (d), the amendments made by sections 201(a), 401, 403, 501, and 502 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 2002 (in this section referred to as the ''general effective date'').

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 201(a), 401, 403, 501, and 502 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (excluding any extension thereof agreed to after the date of the enactment of this Act); or

(B) the general effective date;

but shall apply not later than 1 year after the general effective date. For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Subject to subsection (d), the amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

(d) TRANSITION FOR NOTICE REQUIREMENT.—The disclosure of information required under section 121 of this Act shall first be provided pursuant to—

(1) subsection (a) with respect to a group health plan that is maintained as of the general effective date, not later than 30 days before the beginning of the first plan year to which title I applies in connection with the plan under such subsection; or

(2) subsection (b) with respect to a individual health insurance coverage that is in effect as of the general effective date, not later than 30 days before the first date as of which title I applies to the coverage under such subsection.

SEC. 602. COORDINATION IN IMPLEMENTATION.

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

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

SEC. 603. SEVERABILITY.

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. NO IMPACT ON SOCIAL SECURITY TRUST FUND.

(a) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(b) TRANSFERS.—

(1) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this Act has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such Act.

SEC. 702. CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking ''2003'' and inserting ''2011, except that fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006''.

SEC. 703. FISCAL YEAR 2002 MEDICARE PAYMENTS.

Notwithstanding any other provision of law, any letter of credit under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that would otherwise be sent to the Treasury or the Federal Reserve Board on September 30, 2002, by a carrier with a contract under section 1842 of that Act (42 U.S.C. 1395u) shall be sent on October 1, 2002.

SEC. 704. SENSE OF SENATE WITH RESPECT TO PARTICIPATION IN CLINICAL TRIALS AND ACCESS TO SPECIALTY CARE.

(a) FINDINGS.—The Senate finds the following:

(1) Breast cancer is the most common form of cancer among women, excluding skin cancers.

(2) During 2001, 182,800 new cases of female invasive breast cancer will be diagnosed, and 40,800 women will die from the disease.

(3) In addition, 1,400 male breast cancer cases are projected to be diagnosed, and 400 men will die from the disease.

(4) Breast cancer is the second leading cause of cancer death among all women and the leading cause of cancer death among women between ages 40 and 55.

(5) This year 8,600 children are expected to be diagnosed with cancer.

(6) 1,500 children are expected to die from cancer this year.

(7) There are approximately 333,000 people diagnosed with multiple sclerosis in the United States and 200 more cases are diagnosed each week.

(8) Parkinson's disease is a progressive disorder of the central nervous system affecting 1,000,000 in the United States.

(9) An estimated 198,100 men will be diagnosed with prostate cancer this year.

(10) 31,500 men will die from prostate cancer this year. It is the second leading cause of cancer in men.

(11) While information obtained from clinical trials is essential to finding cures for diseases, it is still research which carries the risk of fatal results. Future efforts should be taken to protect the health and safety of adults and children who enroll in clinical trials.

(12) While employers and health plans should be responsible for covering the routine costs associated with federally approved or funded clinical trials, such employers and health plans should not be held legally responsible for the design, implementation, or outcome of such clinical trials, consistent with any applicable State or Federal liability statutes.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) men and women battling life-threatening, deadly diseases, including advanced breast or ovarian cancer, should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician;

(2) an individual should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician if—

(A) that individual—

(i) has a life-threatening or serious illness for which no standard treatment is effective;

(ii) is eligible to participate in a federally approved or funded clinical trial according to the trial protocol with respect to treatment of the illness;

(B) that individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual; and

(C) either—

(i) the referring physician is a participating health care professional and has concluded that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A); or

(ii) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A);

(3) a child with a life-threatening illness, including cancer, should be allowed to participate in a federally approved or funded clinical trial if that participation meets the requirements of paragraph (2);

(4) a child with a rare cancer should be allowed to go to a cancer center capable of providing high quality care for that disease; and

(5) a health maintenance organization's decision that an in-network physician without the necessary expertise can provide care for a seriously ill patient, including a woman battling cancer, should be appealable to an independent, impartial body, and that this same right should be available to all Americans in need of access to high quality specialty care.

SEC. 705. SENSE OF THE SENATE REGARDING FAIR REVIEW PROCESS.

(a) FINDINGS.—The Senate finds the following:

(1) A fair, timely, impartial independent external appeals process is essential to any meaningful program of patient protection.

(2) The independence and objectivity of the review organization and review process must be ensured.

(3) It is incompatible with a fair and independent appeals process to allow a health maintenance organization to select the review organization that is entrusted with providing a neutral and unbiased medical review.

(4) The American Arbitration Association and arbitration standards adopted under chapter 44 of title 28, United States Code (28 U.S.C. 651 et seq.) both prohibit, as inherently unfair, the right of one party to a dispute to choose the judge in that dispute.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) every patient who is denied care by a health maintenance organization or other health insurance company should be entitled to a fair, speedy, impartial appeal to a review organization that has not been selected by the health plan;

(2) the States should be empowered to maintain and develop the appropriate process for selection of the independent external review entity;

(3) a child battling a rare cancer whose health maintenance organization has denied a covered treatment recommended by its physician should be entitled to a fair and impartial external appeal to a review organization that has not been chosen by the organization or plan that has denied the care; and

(4) patient protection legislation should not pre-empt existing State laws in States where there already are strong laws in place regarding the selection of independent review organizations.

SEC. 706. ANNUAL REVIEW.

(a) IN GENERAL.—Not later than 24 months after the general effective date referred to in section 601(a)(1), and annually thereafter for each of the succeeding 4 calendar years (or until a repeal is effective under subsection (b)), the Secretary of Health and Human Services shall request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this Act, and the amendments made by this Act, on the number of individuals in the United States with health insurance coverage.

(b) LIMITATION WITH RESPECT TO CERTAIN PLANS.—If the Secretary, in any report submitted under subsection (a), determines that more than 1,000,000 individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 402 of this Act shall be repealed effective on the date that is 12 month after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(c) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 2003 and 2004, the Secretary of Health and Human Services shall provide for such funding as the Secretary determines necessary for the conduct of the study of the National Academy of Sciences under this section.

SEC. 707. DEFINITION OF BORN-ALIVE INFANT.

(a) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

''§ 8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant

''(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person', 'human being', 'child', and 'individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

''(b) As used in this section, the term 'born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, or induced abortion.

''(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive as defined in this section.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

''8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.''.

TITLE VIII—REVENUE OFFSETS

Subtitle A—Extension of Custom User Fees

SEC. 801. FURTHER EXTENSION OF AUTHORITY TO LEVY CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)), as amended by section 702, is amended by striking '', except that fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006''.

Subtitle B—Tax Shelter Provisions

PART I—CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE

SEC. 811. CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.

(a) IN GENERAL.—Section 7701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

''(m) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE; ETC.—

''(1) GENERAL RULES.—

''(A) IN GENERAL.—In applying the economic substance doctrine, the determination of whether a transaction has economic substance shall be made as provided in this paragraph.

''(B) DEFINITION OF ECONOMIC SUBSTANCE.—For purposes of subparagraph (A)—

''(i) IN GENERAL.—A transaction has economic substance only if—

''(I) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

''(II) the taxpayer has a substantial nontax purpose for entering into such transaction and the transaction is a reasonable means of accomplishing such purpose.

''(ii) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—A transaction shall not be treated as having economic substance by reason of having a potential for profit unless—

''(I) the present value of the reasonably expected pre-tax profit from the transaction is substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected, and

''(II) the reasonably expected pre-tax profit from the transaction exceeds a risk-free rate of return.

''(C) TREATMENT OF FEES AND FOREIGN TAXES.—Fees and other transaction expenses and foreign taxes shall be taken into account as expenses in determining pre-tax profit under subparagraph (B)(ii).

''(2) SPECIAL RULES FOR TRANSACTIONS WITH TAX-INDIFFERENT PARTIES.—

''(A) SPECIAL RULES FOR FINANCING TRANSACTIONS.—The form of a transaction which is in substance the borrowing of money or the acquisition of financial capital directly or indirectly from a tax-indifferent party shall not be respected if the present value of the deductions to be claimed with respect to the transaction are substantially in excess of the present value of the anticipated economic returns of the person lending the money or providing the financial capital. A public offering shall be treated as a borrowing, or an acquisition of financial capital, from a tax-indifferent party if it is reasonably expected that at least 50 percent of the offering will be placed with tax-indifferent parties.

''(B) ARTIFICIAL INCOME SHIFTING AND BASIS ADJUSTMENTS.—The form of a transaction with a tax-indifferent party shall not be respected if—

''(i) it results in an allocation of income or gain to the tax-indifferent party in excess of such party's economic income or gain, or

''(ii) it results in a basis adjustment or shifting of basis on account of overstating the income or gain of the tax-indifferent party.

''(3) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) ECONOMIC SUBSTANCE DOCTRINE.—The term 'economic substance doctrine' means the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose.

''(B) TAX-INDIFFERENT PARTY.—The term 'tax-indifferent party' means any person or entity not subject to tax imposed by subtitle A. A person shall be treated as a tax-indifferent party with respect to a transaction if the items taken into account with respect to the transaction have no substantial impact on such person's liability under subtitle A.

''(C) EXCEPTION FOR PERSONAL TRANSACTIONS OF INDIVIDUALS.—In the case of an individual, this subsection shall apply only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

''(D) TREATMENT OF LESSORS.—In applying subclause (I) of paragraph (1)(B)(ii) to the lessor of tangible property subject to a lease, the expected net tax benefits shall not include the benefits of depreciation, or any tax credit, with respect to the leased property and subclause (II) of paragraph (1)(B)(ii) shall be disregarded in determining whether any of such benefits are allowable.

''(4) OTHER COMMON LAW DOCTRINES NOT AFFECTED.—Except as specifically provided in this subsection, the provisions of this subsection shall not be construed as altering or supplanting any other rule of law referred to in section 6662(i)(2), and the requirements of this subsection shall be construed as being in addition to any such other rule of law.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions after the date of the enactment of this Act.

PART II—PENALTIES

SEC. 821. INCREASE IN PENALTY ON UNDERPAYMENTS RESULTING FROM FAILURE TO SATISFY CERTAIN COMMON LAW RULES.

(a) IN GENERAL.—Section 6662 of the Internal Revenue Code of 1986 (relating to imposition of accuracy-related penalty) is amended by adding at the end the following new subsection:

''(i) INCREASE IN PENALTY IN CASE OF FAILURE TO SATISFY CERTAIN COMMON LAW RULES.—

''(1) IN GENERAL.—To the extent that an underpayment is attributable to a disallowance described in paragraph (2)—

''(A) subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent', and

''(B) subsection (d)(2)(B) and section 6664(c) shall not apply.

''(2) DISALLOWANCES DESCRIBED.—A disallowance is described in this subsection if such disallowance is on account of—

''(A) a lack of economic substance (within the meaning of section 7701(m)(1)) for the transaction giving rise to the claimed benefit or the transaction was not respected under section 7701(m)(2),

''(B) a lack of business purpose for such transaction or because the form of the transaction does not reflect its substance, or

''(C) a failure to meet the requirements of any other similar rule of law.

''(3) INCREASE IN PENALTY NOT TO APPLY IF COMPLIANCE WITH DISCLOSURE REQUIREMENTS.—Paragraph (1)(A) shall not apply if the taxpayer discloses to the Secretary (as such time and in such manner as the Secretary shall prescribe) such information as the Secretary shall prescribe with respect to such transaction.''.

(b) MODIFICATIONS TO PENALTY ON SUBSTANTIAL UNDERSTATEMENT OF INCOME TAX.—

(1) MODIFICATION OF THRESHOLD.—Subparagraph (A) of section 6662(d)(1) of such Code is amended to read as follows:

''(A) IN GENERAL.—For purposes of this section, there is a substantial understatement of income tax for any taxable year if the amount of the understatement for the taxable year exceeds the lesser of—

''(i) $500,000, or

''(ii) the greater of 10 percent of the tax required to be shown on the return for the taxable year or $5,000.''

(2) MODIFICATION OF PENALTY ON TAX SHELTERS, ETC.—Clauses (i) and (ii) of section 6662(d)(2)(C) of such Code are amended to read as follows:

''(i) IN GENERAL.—Subparagraph (B) shall not apply to any item attributable to a tax shelter.''

''(ii) DETERMINATION OF UNDERSTATEMENTS WITH RESPECT TO TAX SHELTERS, ETC.—In any case in which there are one or more items attributable to a tax shelter, the amount of the understatement under subparagraph (A) shall in no event be less than the amount of understatement which would be determined for the taxable year if all items shown on the return which are not attributable to any tax shelter were treated as being correct. A similar rule shall apply in cases to which subsection (i) applies, whether or not the items are attributable to a tax shelter.''

(c) TREATMENT OF AMENDED RETURNS.—Subsection (a) of section 6664 of such Code is amended by adding at the end the following new sentence: ''For purposes of this subsection, an amended return shall be disregarded if such return is filed on or after the date the taxpayer is first contacted by the Secretary regarding the examination of the return.''

SEC. 822. PENALTY ON PROMOTERS OF TAX AVOIDANCE STRATEGIES WHICH HAVE NO ECONOMIC SUBSTANCE, ETC.

(a) PENALTY.—

(1) IN GENERAL.—Section 6700 of the Internal Revenue Code of 1986 (relating to promoting abusive tax shelters, etc.) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) PENALTY ON SUBSTANTIAL PROMOTERS FOR PROMOTING TAX AVOIDANCE STRATEGIES WHICH HAVE NO ECONOMIC SUBSTANCE, ETC.—

''(1) IMPOSITION OF PENALTY.—Any substantial promoter of a tax avoidance strategy shall pay a penalty in the amount determined under paragraph (2) with respect to such strategy if such strategy (or any similar strategy promoted by such promoter) fails to meet the requirements of any rule of law referred to in section 6662(i)(2).

''(2) AMOUNT OF PENALTY.—The penalty under paragraph (1) with respect to a promoter of a tax avoidance strategy is an amount equal to 100 percent of the gross income derived (or to be derived) by such promoter from such strategy.

''(3) TAX AVOIDANCE STRATEGY.—For purposes of this subsection, the term 'tax avoidance strategy' means any entity, plan, arrangement, or transaction a significant purpose of the structure of which is the avoidance or evasion of Federal income tax.

''(4) SUBSTANTIAL PROMOTER.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'substantial promoter' means, with respect to any tax avoidance strategy, any promoter if—

''(i) such promoter offers such strategy to more than 1 potential participant, and

''(ii) such promoter may receive fees in excess of $500,000 in the aggregate with respect to such strategy.

''(B) AGGREGATION RULES.—For purposes of this paragraph—

''(i) RELATED PERSONS.—A promoter and all persons related to such promoter shall be treated as 1 person who is a promoter.

''(ii) SIMILAR STRATEGIES.—All similar tax avoidance strategies of a promoter shall be treated as 1 tax avoidance strategy.

''(C) PROMOTER.—The term 'promoter' means any person who participates in the promotion, offering, or sale of the tax avoidance strategy.

''(D) RELATED PERSON.—Persons are related if they bear a relationship to each other which is described in section 267(b) or 707(b).

''(4) COORDINATION WITH SUBSECTION (a).—No penalty shall be imposed by this subsection on any promoter with respect to a tax avoidance strategy if a penalty is imposed under subsection (a) on such promoter with respect to such strategy.''

(2) CONFORMING AMENDMENT.—Subsection (d) of section 6700 of such Code is amended—

(A) by striking ''PENALTY'' and inserting ''PENALTIES'', and

(B) by striking ''penalty'' the first place it appears in the text and inserting ''penalties''.

(b) INCREASE IN PENALTY ON PROMOTING ABUSIVE TAX SHELTERS.—The first sentence of section 6700(a) of such Code is amended by striking ''a penalty equal to'' and all that follows and inserting ''a penalty equal to the greater of $1,000 or 100 percent of the gross income derived (or to be derived) by such person from such activity.''

SEC. 823. MODIFICATIONS OF PENALTIES FOR AIDING AND ABETTING UNDERSTATEMENT OF TAX LIABILITY INVOLVING TAX SHELTERS.

(a) IMPOSITION OF PENALTY.—Section 6701(a) of the Internal Revenue Code of 1986 (relating to imposition of penalty) is amended to read as follows:

''(a) IMPOSITION OF PENALTIES.—

''(1) IN GENERAL.—Any person—

''(A) who aids or assists in, procures, or advises with respect to, the preparation or presentation of any portion of a return, affidavit, claim, or other document,

''(B) who knows (or has reason to believe) that such portion will be used in connection with any material matter arising under the internal revenue laws, and

''(C) who knows that such portion (if so used) would result in an understatement of the liability for tax of another person,

shall pay a penalty with respect to each such document in the amount determined under subsection (b).

''(2) CERTAIN TAX SHELTERS.—If—

''(A) any person—

''(i) aids or assists in, procures, or advises with respect to the creation, organization, sale, implementation, management, or reporting of a tax shelter (as defined in section 6662(d)(2)(C)(iii)) or of any entity, plan, arrangement, or transaction that fails to meet the requirements of any rule of law referred to in section 6662(i)(2), and

''(ii) opines, advises, represents, or otherwise indicates (directly or indirectly) that the taxpayer's tax treatment of items attributable to such tax shelter or such entity, plan, arrangement, or transaction and giving rise to an understatement of tax liability would more likely than not prevail or not give rise to a penalty, and

''(B) such opinion, advice, representation, or indication is unreasonable,

then such person shall pay a penalty in the amount determined under subsection (b). If a standard higher than the more likely than not standard was used in any such opinion, advice, representation, or indication, then subparagraph (A)(ii) shall be applied as if such standard were substituted for the more likely than not standard.''

(b) AMOUNT OF PENALTY.—Section 6701(b) of such Code (relating to amount of penalty) is amended—

(1) by inserting ''or (3)'' after ''paragraph (2)'' in paragraph (1),

(2) by striking ''subsection (a)'' each place it appears and inserting ''subsection (a)(1)'', and

(3) by redesignating paragraph (3) as paragraph (4) and by adding after paragraph (2) the following:

''(3) TAX SHELTERS.—In the case of—

''(A) a penalty imposed by subsection (a)(1) which involves a return, affidavit, claim, or other document relating to a tax shelter or an entity, plan, arrangement, or transaction that fails to meet the requirements of any rule of law referred to in section 6662(i)(2), and

''(B) any penalty imposed by subsection (a)(2),

the amount of the penalty shall be equal to 100 percent of the gross proceeds derived (or to be derived) by the person in connection with the tax shelter or entity, plan, arrangement, or transaction.''

(c) REFERRAL AND PUBLICATION.—If a penalty is imposed under section 6701(a)(2) of such Code (as added by subsection (a)) on any person, the Secretary of the Treasury shall—

(1) notify the Director of Practice of the Internal Revenue Service and any appropriate State licensing authority of the penalty and the circumstances under which it was imposed, and

(2) publish the identity of the person and the fact the penalty was imposed on the person.

(d) CONFORMING AMENDMENTS.—

(1) Section 6701(d) of such Code is amended by striking ''Subsection (a)'' and inserting ''Subsection (a)(1)''.

(2) Section 6701(e) of such Code is amended by striking ''subsection (a)(1)'' and inserting ''subsection (a)(1)(A)''.

(3) Section 6701(f) of such Code is amended by inserting '', tax shelter, or entity, plan, arrangement, or transaction'' after ''document'' each place it appears.

SEC. 824. FAILURE TO MAINTAIN LISTS.

Section 6708(a) of the Internal Revenue Code of 1986 (relating to failure to maintain lists of investors in potentially abusive tax shelters) is amended by adding at the end the following: ''In the case of a tax shelter (as defined in section 6662(d)(2)(C)(iii)) or entity, plan, arrangement, or transaction that fails to meet the requirements of any rule of law referred to in section 6662(i)(2), the penalty shall be equal to 50 percent of the gross proceeds derived (or to be derived) from each person with respect to which there was a failure and the limitation of the preceding sentence shall not apply.''

SEC. 825. PENALTY FOR FAILING TO DISCLOSE REPORTABLE TRANSACTION.

(a) IN GENERAL.—Part I of subchapter B of chapter 68 of the Internal Revenue Code of 1986 (relating to assessable penalties) is amended by inserting after section 6707 the following new section:

''SEC. 6707A. PENALTY FOR FAILURE TO INCLUDE TAX SHELTER INFORMATION WITH RETURN.

''(a) IMPOSITION OF PENALTY.—Any person who fails to include with its return of Federal income tax any information required to be included under section 6011 with respect to a reportable transaction shall pay a penalty in the amount determined under subsection (b). No penalty shall be imposed on any such failure if it is shown that such failure is due to reasonable cause.

''(b) AMOUNT OF PENALTY.—

''(1) IN GENERAL.—The amount of the penalty under subsection (a) shall be equal to the greater of—

''(A) 5 percent of any increase in Federal tax which results from a difference between the taxpayer's treatment (as shown on its return) of items attributable to the reportable transaction to which the failure relates and the proper tax treatment of such items, or

''(B) $100,000.

For purposes of subparagraph (A), the last sentence of section 6664(a) shall apply.

''(2) LISTED TRANSACTION.—If the failure under subsection (a) relates to a reportable transaction which is the same as, or substantially similar to, a transaction specifically identified by the Secretary as a tax avoidance transaction for purposes of section 6011, paragraph (1)(A) shall be applied by substituting '10 percent' for '5 percent'.

''(c) REPORTABLE TRANSACTION.—For purposes of this section, the term 'reportable transaction' means any transaction with respect to which information is required under section 6011 to be included with a taxpayer's return of tax because, as determined under regulations prescribed under section 6011, such transaction has characteristics which may be indicative of a tax avoidance transaction.

''(d) COORDINATION WITH OTHER PENALTIES.—The penalty imposed by this section is in addition to any penalty imposed under section 6662.''

(b) CONFORMING AMENDMENT.—The table of sections for part I of subchapter B of chapter 68 of such Code is amended by inserting after the item relating to section 6707 the following:

''Sec. 6707A. Penalty for failure to include tax shelter information on return.''

SEC. 826. REGISTRATION OF CERTAIN TAX SHELTERS WITHOUT CORPORATE PARTICIPANTS.

Section 6111(d)(1)(A) of the Internal Revenue Code of 1986 (relating to certain confidential arrangements treated as tax shelters) is amended by striking ''for a direct or indirect participant which is a corporation''.

SEC. 827. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsections (b), (c), and (d), the amendments made by this subtitle shall apply to transactions after the date of the enactment of this Act.

(b) SECTION 821.—The amendments made by subsections (b) and (c) of section 821 shall apply to taxable years ending after the date of the enactment of this Act.

(c) SECTION 822.—The amendments made by subsection (a) of section 822 shall apply to any tax avoidance strategy (as defined in section 6700(c) of the Internal Revenue Code of 1986, as amended by this title) interests in which are offered to potential participants after the date of the enactment of this Act.

(d) SECTION 826.—The amendment made by section 826 shall apply to any tax shelter interest which is offered to potential participants after the date of the enactment of this Act.

PART III—LIMITATIONS ON IMPORTATION OR TRANSFER OF BUILT-IN LOSSES

SEC. 831. LIMITATION ON IMPORTATION OF BUILT-IN LOSSES.

(a) IN GENERAL.—Section 362 of the Internal Revenue Code of 1986 (relating to basis to corporations) is amended by adding at the end the following new subsection:

''(e) LIMITATION ON IMPORTATION OF BUILT-IN LOSSES.—

''(1) IN GENERAL.—If in any transaction described in subsection (a) or (b) there would (but for this subsection) be an importation of a net built-in loss, the basis of each property described in paragraph (2) which is acquired in such transaction shall (notwithstanding subsections (a) and (b)) be its fair market value immediately after such transaction.

''(2) PROPERTY DESCRIBED.—For purposes of paragraph (1), property is described in this paragraph if—

''(A) gain or loss with respect to such property is not subject to tax under this subtitle in the hands of the transferor immediately before the transfer, and

''(B) gain or loss with respect to such property is subject to such tax in the hands of the transferee immediately after such transfer.

In any case in which the transferor is a partnership, the preceding sentence shall be applied by treating each partner in such partnership as holding such partner's proportionate share of the property of such partnership.

''(3) IMPORTATION OF NET BUILT-IN LOSS.—For purposes of paragraph (1), there is an importation of a net built-in loss in a transaction if the transferee's aggregate adjusted bases of property described in paragraph (2) which is transferred in such transaction would (but for this subsection) exceed the fair market value of such property immediately after such transaction.''

(b) COMPARABLE TREATMENT WHERE LIQUIDATION.—Paragraph (1) of section 334(b) of such Code (relating to liquidation of subsidiary) is amended to read as follows:

''(1) IN GENERAL.—If property is received by a corporate distributee in a distribution in a complete liquidation to which section 332 applies (or in a transfer described in section 337(b)(1)), the basis of such property in the hands of such distributee shall be the same as it would be in the hands of the transferor; except that the basis of such property in the hands of such distributee shall be the fair market value of the property at the time of the distribution—

''(A) in any case in which gain or loss is recognized by the liquidating corporation with respect to such property, or

''(B) in any case in which the liquidating corporation is a foreign corporation, the corporate distributee is a domestic corporation, and the corporate distributee's aggregate adjusted bases of property described in section 362(e)(2) which is distributed in such liquidation would (but for this subparagraph) exceed the fair market value of such property immediately after such liquidation.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions after the date of the enactment of this Act.

SEC. 832. DISALLOWANCE OF PARTNERSHIP LOSS TRANSFERS.

(a) TREATMENT OF CONTRIBUTED PROPERTY WITH BUILT-IN LOSS.—Paragraph (1) of section 704(c) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting '', and'', and by adding at the end the following:

''(C) if any property so contributed has a built-in loss—

''(i) such built-in loss shall be taken into account only in determining the amount of items allocated to the contributing partner, and

''(ii) except as provided in regulations, in determining the amount of items allocated to other partners, the basis of the contributed property in the hands of the partnership shall be treated as being equal to its fair market value immediately after the contribution.

For purposes of subparagraph (C), the term 'built-in loss' means the excess of the adjusted basis of the property over its fair market value immediately after the contribution.''

(b) ADJUSTMENT TO BASIS OF PARTNERSHIP PROPERTY ON TRANSFER OF PARTNERSHIP INTEREST IF THERE IS SUBSTANTIAL BUILT-IN LOSS.—

(1) ADJUSTMENT REQUIRED.—Subsection (a) of section 743 of such Code (relating to optional adjustment to basis of partnership property) is amended by inserting before the period ''or unless the partnership has a substantial built-in loss immediately after such transfer''.

(2) ADJUSTMENT.—Subsection (b) of section 743 of such Code is amended by inserting ''or with respect to which there is a substantial built-in loss immediately after such transfer'' after ''section 754 is in effect''.

(3) SUBSTANTIAL BUILT-IN LOSS.—Section 743 of such Code is amended by adding at the end the following new subsection:

''(d) SUBSTANTIAL BUILT-IN LOSS.—For purposes of this section, a partnership has a substantial built-in loss with respect to a transfer of an interest in a partnership if the transferee partner's proportionate share of the adjusted basis of the partnership property exceeds 110 percent of the basis of such partner's interest in the partnership.''

(4) CLERICAL AMENDMENTS.—

(A) The section heading for section 743 of such Code is amended to read as follows:

''SEC. 743. ADJUSTMENT TO BASIS OF PARTNERSHIP PROPERTY WHERE SECTION 754 ELECTION OR SUBSTANTIAL BUILT-IN LOSS.''

(B) The table of sections for subpart C of part II of subchapter K of chapter 1 of such Code is amended by striking the item relating to section 743 and inserting the following new item:

''Sec. 743. Adjustment to basis of partnership property where section 754 election or substantial built-in loss.''

(c) ADJUSTMENT TO BASIS OF UNDISTRIBUTED PARTNERSHIP PROPERTY IF THERE IS SUBSTANTIAL BASIS REDUCTION.—

(1) ADJUSTMENT REQUIRED.—Subsection (a) of section 734 of such Code (relating to optional adjustment to basis of undistributed partnership property) is amended by inserting before the period ''or unless there is a substantial basis reduction''.

(2) ADJUSTMENT.—Subsection (b) of section 734 of such Code is amended by inserting ''or unless there is a substantial basis reduction'' after ''section 754 is in effect''.

(3) SUBSTANTIAL BASIS REDUCTION.—Section 734 of such Code is amended by adding at the end the following new subsection:

''(d) SUBSTANTIAL BASIS REDUCTION.—For purposes of this section, there is a substantial basis reduction with respect to a distribution if the sum of the amounts described in subparagraphs (A) and (B) of subsection (b)(2) exceeds 10 percent of the aggregate adjusted basis of partnership property immediately after the distribution.''

(4) CLERICAL AMENDMENTS.—

(A) The section heading for section 734 of such Code is amended to read as follows:

''SEC. 734. ADJUSTMENT TO BASIS OF UNDISTRIBUTED PARTNERSHIP PROPERTY WHERE SECTION 754 ELECTION OR SUBSTANTIAL BASIS REDUCTION.''

(B) The table of sections for subpart B of part II of subchapter K of chapter 1 of such Code is amended by striking the item relating to section 734 and inserting the following new item:

''Sec. 734. Adjustment to basis of undistributed partnership property where section 754 election or substantial basis reduction.''

(d) EFFECTIVE DATES.—

(1) SUBSECTION (a).—The amendment made by subsection (a) shall apply to contributions made after the date of the enactment of this Act.

(2) SUBSECTION (b).—The amendments made by subsection (a) shall apply to transfers after the date of the enactment of this Act.

(3) SUBSECTION (c).—The amendments made by subsection (a) shall apply to distributions after the date of the enactment of this Act.

Mr. BERRY (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Arkansas (Mr. BERRY) is recognized for 5 minutes in support of his motion to recommit.

Mr. BERRY. Mr. Speaker, this motion to recommit is very simple. It is the underlying bill that we are considering today, H.R. 2563, the true Bipartisan Patient Protection Act, but with one important difference: The costs of the bill are entirely paid for in the motion to recommit.

The sponsors of the Bipartisan Patient Protection Act had committed ourselves to paying for the cost of the bill, and we added these pay-fors when we presented a substitute to the Committee on Rules. However, the Committee on Rules would not even let us offer this substitute.

The underlying bill, the Bipartisan Patient Protection Act, is nearly the same as the Senate-passed bill. It was a bill that was debated for 2 weeks by the Senate, not 2 hours. It was ultimately passed by the Senate in a true bipartisan majority of 59, just like a true bipartisan majority passed a similar bill here in the last Congress.

However, this motion to recommit is even better than either of those bills because it keeps our promise that nearly every Member of this House, nearly every Member that sits this evening here on this floor has promised to pay for our bills and not to raid the Medicare and Social Security trust fund.

Mr. Speaker, this is a commitment we have made to the American people, and it should be honored. The provisions to pay for the bill are good government provisions. They continue the existing customs fees, as did the Senate, and they crack down on sham business enterprises designed solely to generate tax benefits. Nothing in the recently passed bill is changed.

I want to remind my colleagues that because the Committee on Rules did not make these provisions in order, this motion to recommit is Members' only opportunity to vote for an amendment to pay for this bill. It is Members' only chance not to rob the Medicare and Social Security trust funds.

I urge a ''yes'' vote.

Mr. Speaker, I yield the balance of my time to the gentleman from South Carolina (Mr. SPRATT), the ranking member of the Committee on the Budget.

Mr. SPRATT. Mr. Speaker, day by day, bill by bill, the surplus is washing away. The House is driving this budget straight into the Medicare trust fund.

Yesterday, it was the energy bill, with an impact on the budget, according to the Congressional Budget Office, of $33 billion over 10 years. Today it is the Patients' Bill of Rights whose impact is $15 billion to $25 billion brought to the floor without being scored.

In each case, Democrats have offered offsets to protest the trust funds and the surplus, and in each case, Republicans spurned the offer of offsets.

Mr. Speaker, in 2 days, this House will have whacked $40 to $50 billion out of the surplus. It is a good thing we are going home.

Mr. Speaker, let me warn Members, mid-August when we are at home, the Congressional Budget Office will complete its midyear update of the budget, and when we come back, there will be no question, the House will be in the Medicare trust fund. That is where the budget activity today will have taken us, by passing bills like this and paying no heed whatsoever to the budget. Bring it up, ignore the offset.

I direct Members' attention to this chart. This shows what thin ice the budget is now sitting on. After the energy bill last night and the defense bill we reported yesterday, there is a $12 billion bottom line remainder in fiscal year 2002. That is black.

But if we come down here to where we have estimated the August update by the Congressional Budget Office, and we have only estimated that they will take the economy down by one-half of one percentage point in the next year, Members will see that black 12 turns to a red 16. We go from a surplus of $12 to $16 billion in deficit, meaning we are $16 billion into the Medicare trust fund. So much for the lockbox. That is not just 1 year, it is every year from now until 2011; so much so, we consume the entire Medicare surplus over this period of time.

Mr. Speaker, the only honest vote is for the motion to recommit, which will pay for this bill.

Mr. TAUZIN. Mr. Speaker, I rise in opposition to the motion to recommit.

Mr. Speaker, I would say to the gentleman if we would be so foolish as to adopt this motion to recommit and pass tonight a $7.5 billion tax increase, Americans might not want us to come home.

This motion to recommit not only would put forward this $7.5 billion tax increase, but as Members know, it would undo the good work of this House in endorsing the great work the gentleman from Georgia (Mr. NORWOOD) has done in reaching agreement on the contentious issue of liability.

Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. BOEHNER), the chairman of the Committee on Education and the Workforce.

Mr. BOEHNER. Mr. Speaker, the gentleman from Louisiana (Mr. TAUZIN)

mentioned that we would go back to the original liability that would drive employers out of the system, drive up costs for employers and their employees. We do not want to do that.

It would also eliminate the association health plans that we have worked so hard on over the last 10 years to try to help small employers provide health insurance for their employees.

But of all things, after 40 years of one party controlling this House and balancing the budget one time in 40 years, to stand in the well of the House and say that this bill will bust the budget, please, give me a break.

Mr. TAUZIN. Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, the gentleman said that this is the same bill. I know he does not want to revisit the passage of the Norwood amendment. It passed. And what is not in the bill now with the Norwood amendment is what is in this underlying bill.

I invite Members to turn to page 121 where it says on line 15, ''no preemption of State law.'' And then down on line 4 it says, ''no right of action for recovery, indemnity or contribution by issuers against treating health care professionals and treating hospitals.'' They gave it on line 14, and took it away on line 34. Thank goodness that is no longer in the bill.

Let us visit the tax portion. What the Congressional Budget Office said was that if this became law, their bill, the one we changed, it would increase premiums 5 percent.

□ 2200

It does not sound like a lot, but guess what employers do? They will then, because their health costs are higher in terms of the insurance, lower the wages. The Congressional Budget Office says they do. You have to make up that because there is lower revenue. The Congressional Budget Office says that your legislation reduces income and the HI payroll tax, that is the Medicare Trust Fund, by $13 billion over 10 years. That is true; but remember, he proudly said, there was a tax increase in here. The tax increase that is in here increases the general fund because it is revenue. Now, that is good because they take general fund revenue and put it over in Social Security to make up the lost money because, remember, that payroll reduction also affects the Social Security payroll tax fund.

So what they have done is taken general fund money and put it in the Social Security fund, but the corporate tax increase only goes into the general fund. You heard the gentleman on the floor. Guess who invades the HI trust fund? According to the Congressional Budget Office, their underlying bill, the one we are going to vote down in just a minute, decreases income and HI payroll taxes by $13.4 billion. The corporate tax provision in their bill can only go into general revenue. It cannot cover HI.

They reduce the HI trust fund. Ironically, my friends, if you want to protect the HI trust fund, vote ''no'' on the motion to recommit.

The SPEAKER pro tempore (Mr. BEREUTER). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. BERRY. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 208, noes 220, not voting 6, as follows:

[Roll No. 331]

AYES—208

Abercrombie	Gordon	Mollohan
Ackerman	Green (TX)	Moore
Allen	Gutierrez	Moran (VA)
Andrews	Hall (OH)	Morella
Baca	Hall (TX)	Murtha
Baird	Harman	Nadler
Baldacci	Hastings (FL)	Napolitano
Baldwin	Hill	Neal
Barcia	Hilliard	Oberstar
Barrett	Hinchey	Obey
Becerra	Hinojosa	Olver
Bentsen	Hoeffel	Ortiz
Berkley	Holden	Owens
Berman	Holt	Pallone
Berry	Honda	Pascrell
Bishop	Hooley	Pastor
Blagojevich	Hoyer	Payne
Blumenauer	Inslee	Pelosi
Bonior	Israel	Phelps
Borski	Jackson (IL)	Pomeroy
Boswell	Jackson-Lee (TX)	Price (NC)
Boucher	Jefferson	Rahall
Boyd	John	Rangel
Brady (PA)	Johnson, E. B.	Reyes
Brown (FL)	Jones (OH)	Rivers
Brown (OH)	Kanjorski	Rodriguez
Capps	Kaptur	Roemer
Capuano	Kennedy (RI)	Ross
Cardin	Kildee	Rothman
Carson (IN)	Kilpatrick	Roybal-Allard
Carson (OK)	Kind (WI)	Rush
Clay	Kleczka	Sabo
Clayton	Kucinich	Sanchez
Clement	LaFalce	Sanders
Clyburn	Lampson	Sandlin
Condit	Langevin	Sawyer
Conyers	Lantos	Schakowsky
Costello	Larsen (WA)	Schiff
Coyne	Larson (CT)	Scott
Cramer	Leach	Serrano
Crowley	Lee	Sherman
Cummings	Levin	Shows
Davis (CA)	Lewis (GA)	Skelton
Davis (FL)	Lofgren	Slaughter
Davis (IL)	Lowey	Smith (WA)
DeFazio	Luther	Snyder
DeGette	Maloney (CT)	Solis
Delahunt	Maloney (NY)	Spratt
DeLauro	Markey	Stark
Deutsch	Mascara	Stenholm
Dicks	Matheson	Strickland
Dingell	Matsui	Tanner
Doggett	McCarthy (MO)	Tauscher
Dooley	McCarthy (NY)	Taylor (MS)
Doyle	McCollum	Thompson (MS)
Edwards	McDermott	Thurman
Engel	McGovern	Tierney
Eshoo	McIntyre	Towns
Etheridge	McKinney	Turner
Evans	McNulty	Udall (CO)
Farr	Meehan	Udall (NM)
Fattah	Meek (FL)	Velazquez
Filner	Meeks (NY)	Visclosky
Ford	Menendez	Waters
Frank	Millender-McDonald	Watson (CA)
Frost	Miller, George	Watt (NC)
Ganske	Mink	Waxman
Gephardt	Wexler	Weiner
Gonzalez	Woolsey	Wu
		Wynn

NOES—220

Aderholt	Graham	Petri
Akin	Granger	Pickering
Armey	Graves	Pitts
Bachus	Green (WI)	Platts
Baker	Greenwood	Pombo
Ballenger	Grucci	Portman
Barr	Gutknecht	Pryce (OH)
Bartlett	Hansen	Putnam
Barton	Hart	Quinn
Bass	Hastert	Radanovich
Bereuter	Hastings (WA)	Ramstad
Biggert	Hayes	Regula
Bilirakis	Hayworth	Rehberg
Blunt	Hefley	Reynolds
Boehlert	Herger	Riley
Boehner	Hilleary	Rogers (KY)
Bonilla	Hobson	Rogers (MI)
Bono	Hoekstra	Rohrabacher
Brady (TX)	Horn	Ros-Lehtinen
Brown (SC)	Hostettler	Roukema
Bryant	Houghton	Royce
Burr	Hulshof	Ryan (WI)
Burton	Hunter	Ryun (KS)
Buyer	Hutchinson	Saxton
Callahan	Hyde	Scarborough
Calvert	Isakson	Schaffer
Camp	Issa	Schrock
Cannon	Istook	Sensenbrenner
Cantor	Jenkins	Sessions
Capito	Johnson (CT)	Shadegg
Castle	Johnson (IL)	Shaw
Chabot	Johnson, Sam	Shays
Chambliss	Jones (NC)	Sherwood
Coble	Keller	Shimkus
Collins	Kelly	Shuster
Combest	Kennedy (MN)	Simmons
Cooksey	Kerns	Simpson
Cox	King (NY)	Skeen
Crane	Kingston	Smith (MI)
Crenshaw	Kirk	Smith (NJ)
Cubin	Knollenberg	Smith (TX)
Culberson	Kolbe	Souder
Cunningham	LaHood	Stearns
Davis, Jo Ann	Largent	Stump
Davis, Tom	Latham	Sununu
Deal	LaTourette	Sweeney
DeLay	Lewis (CA)	Tancredo
DeMint	Lewis (KY)	Tauzin
Diaz-Balart	Linder	Taylor (NC)
Doolittle	LoBiondo	Terry
Dreier	Lucas (KY)	Thomas
Duncan	Lucas (OK)	Thornberry
Dunn	Manzullo	Thune
Ehlers	McCrery	Tiahrt
Ehrlich	McHugh	Tiberi
Emerson	McInnis	Toomey
English	McKeon	Traficant
Everett	Mica	Upton
Ferguson	Miller (FL)	Vitter
Flake	Miller, Gary	Walden
Fletcher	Moran (KS)	Walsh
Foley	Myrick	Wamp
Forbes	Nethercutt	Watkins (OK)
Fossella	Ney	Watts (OK)
Frelinghuysen	Northup	Weldon (FL)
Gallegly	Norwood	Weller
Gekas	Nussle	Whitfield
Gibbons	Osborne	Wicker
Gilchrest	Ose	Wilson
Gillmor	Otter	Wolf
Gilman	Oxley	Young (AK)
Goode	Pence	Young (FL)
Goodlatte	Peterson (MN)	
Goss	Peterson (PA)	

NOT VOTING—6

Lipinski	Spence	Thompson (CA)
Paul	Stupak	Weldon (PA)

□ 2218

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. STUPAK. Mr. Speaker, on rollcall vote number 331, I was unavoidably detained and missed that vote. Had I been here, I would have voted ''aye.''

(Mr. SNYDER asked and was given permission to speak out of order for 1 minute.)

CONGRATULATIONS AND FAREWELL TO OUR COLLEAGUE, THE HONORABLE ASA HUTCHINSON

Mr. SNYDER. Mr. Speaker, the hour is late, but it is never too late to say good-bye and hello to a friend; good-bye to ASA HUTCHINSON, Congressman, and hello to the new head of the DEA, ASA HUTCHINSON.

ASA, we will miss you.

Mr. Speaker, I yield to the gentleman from Missouri (Mr. HULSHOF).

Mr. HULSHOF. Mr. Speaker, I, too, want to add my accolades to the departing Member, a classmate of mine, who came in in the 105th Congress.

The gentleman from Arkansas has served with distinction the Third Congressional District of Arkansas since his election. As ASA tells it, the folks back home in Arkansas were not too impressed about this DEA nomination, until they found out that he would be the head of 9,000 employees and have offices in over 50 countries, at which point they then thought it was kind of a big deal.

ASA, of course, served with distinction on the Committee on the Judiciary, and, as some of you who worked with him knew, he was thrust into an interesting role with the impeachment matter. But he has also been a leader on other issues regarding the Federal Judiciary, whether it is regarding our forfeiture laws, whether it is racial profiling, or campaign finance.

I think all of those issues, and the open mindedness that ASA brought to those issues, is one reason there was such a tremendous show of support, when every one of his colleagues on the Democratic side of the aisle on the Committee on the Judiciary signed a letter of support to the Senate Committee on the Judiciary, urging ASA's confirmation. I think that was a tremendous show of bipartisan support.

Finally, Mr. Speaker, ASA, we simply say to you that as you continue your service to this great Nation, that we wish you and Susan and your family Godspeed. We all in this Chamber have been enriched by having known you, and we are luckier all the more for the fact that we have had a chance to work with you.

We wish you well.

The SPEAKER pro tempore (Mr. BEREUTER). The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. MCDERMOTT. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 226, nays 203, not voting 5, as follows:

[Roll No. 332]

YEAS—226

Aderholt	Bartlett	Boehlert
Akin	Barton	Boehner
Armey	Bass	Bonilla
Bachus	Bereuter	Bono
Baker	Biggert	Brady (TX)
Ballenger	Bilirakis	Brown (SC)
Barr	Blunt	Bryant
Burr	Herger	Putnam
Burton	Hilleary	Quinn
Buyer	Hobson	Radanovich
Callahan	Hoekstra	Ramstad
Calvert	Horn	Regula
Camp	Hostettler	Rehberg
Cannon	Houghton	Reynolds
Cantor	Hulshof	Riley
Capito	Hunter	Rogers (KY)
Castle	Hutchinson	Rogers (MI)
Chabot	Hyde	Rohrabacher
Chambliss	Isakson	Ros-Lehtinen
Coble	Issa	Roukema
Collins	Istook	Royce
Combest	Jenkins	Ryan (WI)
Cooksey	Johnson (CT)	Ryun (KS)
Cox	Johnson (IL)	Saxton
Cramer	Johnson, Sam	Scarborough
Crane	Jones (NC)	Schaffer
Crenshaw	Keller	Schrock
Cubin	Kelly	Sensenbrenner
Culberson	Kennedy (MN)	Sessions
Cunningham	Kerns	Shadegg
Davis, Jo Ann	King (NY)	Shaw
Davis, Tom	Kingston	Shays
Deal	Kirk	Sherwood
DeLay	Knollenberg	Shimkus
DeMint	Kolbe	Shuster
Diaz-Balart	LaHood	Simmons
Doolittle	Largent	Simpson
Dreier	Latham	Skeen
Duncan	LaTourette	Smith (MI)
Dunn	Leach	Smith (NJ)
Ehlers	Lewis (CA)	Smith (TX)
Ehrlich	Lewis (KY)	Smith (WA)
Emerson	Linder	Souder
English	LoBiondo	Stearns
Everett	Lucas (KY)	Stump
Ferguson	Lucas (OK)	Sununu
Flake	Manzullo	Sweeney
Fletcher	McCrery	Tancredo
Foley	McHugh	Tauzin
Forbes	McInnis	Taylor (NC)
Fossella	McKeon	Terry
Frelinghuysen	Mica	Thomas
Gallegly	Miller (FL)	Thornberry
Ganske	Miller, Gary	Thune
Gekas	Moran (KS)	Tiahrt
Gibbons	Morella	Tiberi
Gilchrest	Myrick	Toomey
Gillmor	Nethercutt	Traficant
Gilman	Ney	Upton
Goode	Northup	Vitter
Goodlatte	Norwood	Walden
Goss	Nussle	Walsh
Graham	Osborne	Wamp
Granger	Ose	Watkins (OK)
Graves	Otter	Watts (OK)
Green (WI)	Oxley	Weldon (FL)
Greenwood	Pence	Weldon (PA)
Grucci	Peterson (MN)	Weller
Gutknecht	Peterson (PA)	Whitfield
Hansen	Petri	Wicker
Hart	Pickering	Wilson
Hastert	Pitts	Wolf
Hastings (WA)	Platts	Young (AK)
Hayes	Pombo	Young (FL)
Hayworth	Portman	
Hefley	Pryce (OH)	

NAYS—203

Abercrombie	Cardin	Eshoo
Ackerman	Carson (IN)	Etheridge
Allen	Carson (OK)	Evans
Andrews	Clay	Farr
Baca	Clayton	Fattah
Baird	Clement	Filner
Baldacci	Clyburn	Ford
Baldwin	Condit	Frank
Barcia	Conyers	Frost
Barrett	Costello	Gephardt
Becerra	Coyne	Gonzalez
Bentsen	Crowley	Gordon
Berkley	Cummings	Green (TX)
Berman	Davis (CA)	Gutierrez
Berry	Davis (FL)	Hall (OH)
Bishop	Davis (IL)	Hall (TX)
Blagojevich	DeFazio	Harman
Blumenauer	DeGette	Hastings (FL)
Bonior	Delahunt	Hill
Borski	DeLauro	Hilliard
Boswell	Deutsch	Hinchey
Boucher	Dicks	Hinojosa
Boyd	Dingell	Hoeffel
Brady (PA)	Doggett	Holden
Brown (FL)	Dooley	Holt
Brown (OH)	Doyle	Honda
Capps	Edwards	Hooley
Capuano	Engel	Hoyer
Inslee	McKinney	Sanchez
Israel	McNulty	Sanders
Jackson (IL)	Meehan	Sandlin
Jackson-Lee (TX)	Meek (FL)	Sawyer
Jefferson	Meeks (NY)	Schakowsky
John	Menendez	Schiff
Johnson, E. B.	Millender-McDonald	Scott
Jones (OH)	Miller, George	Serrano
Kanjorski	Mink	Sherman
Kaptur	Mollohan	Shows
Kennedy (RI)	Moore	Skelton
Kildee	Moran (VA)	Slaughter
Kilpatrick	Murtha	Snyder
Kind (WI)	Nadler	Spratt
Kleczka	Napolitano	Stark
Kucinich	Neal	Stenholm
LaFalce	Oberstar	Strickland
Lampson	Obey	Stupak
Langevin	Olver	Tanner
Lantos	Ortiz	Tauscher
Larsen (WA)	Owens	Taylor (MS)
Larson (CT)	Pallone	Thompson (MS)
Lee	Pascrell	Thurman
Levin	Pastor	Tierney
Lewis (GA)	Payne	Towns
Lofgren	Pelosi	Turner
Lowey	Phelps	Udall (CO)
Luther	Pomeroy	Udall (NM)
Maloney (CT)	Price (NC)	Velazquez
Maloney (NY)	Rahall	Visclosky
Markey	Rangel	Waters
Mascara	Reyes	Watson (CA)
Matheson	Rivers	Watt (NC)
Matsui	Rodriguez	Waxman
McCarthy (MO)	Roemer	Weiner
McCarthy (NY)	Ross	Wexler
McCollum	Rothman	Woolsey
McDermott	Roybal-Allard	Wu
McGovern	Rush	Wynn
McIntyre	Sabo	

NOT VOTING—5

Lipinski	Solis	Thompson (CA)
Paul	Spence	

□ 2342

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to recommit was laid on the table.

AUTHORIZING THE CLERK TO MAKE CORRECTIONS TO THE ENGROSSMENT OF H.R. 2563, BIPARTISAN PATIENT PROTECTION ACT

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that in the engrossment of the bill, H.R. 2563, the Clerk be authorized to correct section numbers, punctuation, and cross-references, and to make such other technical and conforming changes as may be necessary to reflect the actions of the House in amending the bill, H.R. 2563.

The SPEAKER. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

PERMISSION FOR COMMITTEE ON ARMED SERVICES TO HAVE UNTIL SEPTEMBER 4, 2001 TO FILE REPORT ON H.R. 2586, NATIONAL DEFENSE AUTHORIZATION ACT, 2002

Mr. STUMP. Mr. Speaker, I ask unanimous consent that the Committee on Armed Services have until September 4, 2001 to file a report to accompany the bill H.R. 2586.

The SPEAKER. Is there objection to the request of the gentleman from Arizona?