106TH CONGRESS
1ST SESSION

H. R. 2723

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

IN THE HOUSE OF REPRESENTATIVES

AUGUST 5, 1999

Mr. NORWOOD (for himself, Mr. DINGELL, Mr. GANSKE, Mr. COOKSEY, Mr. BERRY, Mrs. CLAYTON, Mr. GRAHAM, Mr. PALLONE, Mrs. ROUKEMA, Mrs. CAPPS, Mr. SHAW, Mr. JOHN, Mr. SHAYS, Mr. TURNER, Mrs. CUBIN, Mr. BALDACCI, Mr. FOLEY, Mr. GEPHARDT, Mr. HOUGHTON, Mr. RANGEL, Mr. HORN, Mr. CLAY, Mr. GIBBONS, Mr. BROWN of Ohio, Mr. FRELINGHUYSEN, Mr. ANDREWS, Mr. GILCHREST, Mr. STARK, Mr. LEACH, Mr. WAXMAN, Mr. GILMAN, Mr. CARDIN, Mr. LATOURETTE, Mr. FORD, Mr. LOBIONDO, Mr. SANDLIN, Mr. BARR of Georgia, Mrs. THURMAN, Mr. BOEHLERT, Mr. KLINK, Mrs. MORELLA, Mr. SNYDER, Ms. ESHOO, Mr. DOYLE, Mr. MCDERMOTT, Mr. BRADY of Pennsylvania, Mr. PASCRELL, Mr. HOLT, Mr. FROST, Ms. KILPATRICK, Mr. DICKS, Ms. SCHAKOWSKY, Mr. RUSH, Mrs. MCCARTHY of New York, Mr. MURTHA, Ms. STABENOW, Mr. PHELPS, Mr. HALL of Texas, Mr. WEYGAND, Ms. BERKLEY, Mr. WYNN, Mr. TANNER, Mr. BOUCHER, Mr. BARRETT of Wisconsin, Mr. FORBES, and Mr. BONIOR) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to pro-

tect consumers in managed care plans and other health coverage.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 "Bipartisan Consensus Managed Care Improvement Act
6 of 1999".

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

Sec. 101. Utilization review activities.
Sec. 102. Internal appeals procedures.
Sec. 103. External appeals procedures.
Sec. 104. Establishment of a grievance process.

Subtitle B—Access to Care

Sec. 111. Consumer choice option.
Sec. 112. Choice of health care professional.
Sec. 113. Access to emergency care.
Sec. 114. Access to specialty care.
Sec. 115. Access to obstetrical and gynecological care.
Sec. 116. Access to pediatric care.
Sec. 117. Continuity of care.
Sec. 118. Access to needed prescription drugs.
Sec. 119. Coverage for individuals participating in approved clinical trials.

Subtitle C—Access to Information

Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

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

Subtitle E—Definitions

Sec. 151. Definitions.
Sec. 152. Preemption; State flexibility; construction.
Sec. 153. Exclusions.
Sec. 154. Coverage of limited scope plans.
Sec. 155. Regulations.

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

Sec. 201. Application to group health plans and group health insurance coverage.
Sec. 202. Application to individual health insurance coverage.

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

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

Sec. 401. Amendments to the Internal Revenue Code of 1986.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

Sec. 501. Effective dates.
Sec. 502. Coordination in implementation.

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

Sec. 601. Health care paperwork simplification.

1 # TITLE I—IMPROVING MANAGED
2 # CARE

3 ## Subtitle A—Grievance and Appeals

4 **SEC. 101. UTILIZATION REVIEW ACTIVITIES.**

5 (a) COMPLIANCE WITH REQUIREMENTS.—

6 (1) IN GENERAL.—A group health plan, and a
7 health insurance issuer that provides health insur-
8 ance coverage, shall conduct utilization review activi-
9 ties in connection with the provision of benefits

1 under such plan or coverage only in accordance with
2 a utilization review program that meets the require-
3 ments of this section.

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

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

21 (b) WRITTEN POLICIES AND CRITERIA.—

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

1 (2) USE OF WRITTEN CRITERIA.—
2 (A) IN GENERAL.—Such a program shall
3 utilize written clinical review criteria developed
4 with input from a range of appropriate actively
5 practicing health care professionals, as deter-
6 mined by the plan, pursuant to the program.
7 Such criteria shall include written clinical re-
8 view criteria that are based on valid clinical evi-
9 dence where available and that are directed spe-
10 cifically at meeting the needs of at-risk popu-
11 lations and covered individuals with chronic
12 conditions or severe illnesses, including gender-
13 specific criteria and pediatric-specific criteria
14 where available and appropriate.
15 (B) CONTINUING USE OF STANDARDS IN
16 RETROSPECTIVE REVIEW.—If a health care
17 service has been specifically pre-authorized or
18 approved for an enrollee under such a program,
19 the program shall not, pursuant to retrospective
20 review, revise or modify the specific standards,
21 criteria, or procedures used for the utilization
22 review for procedures, treatment, and services
23 delivered to the enrollee during the same course
24 of treatment.

1 (C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an 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.

1 (C) PROHIBITION OF CONFLICTS.—Such a
2 program shall not permit a health care profes-
3 sional who is providing health care services to
4 an individual to perform utilization review ac-
5 tivities in connection with the health care serv-
6 ices being provided to the individual.
7 (3) ACCESSIBILITY OF REVIEW.—Such a pro-
8 gram shall provide that appropriate personnel per-
9 forming utilization review activities under the pro-
10 gram, including the utilization review administrator,
11 are reasonably accessible by toll-free telephone dur-
12 ing normal business hours to discuss patient care
13 and allow response to telephone requests, and that
14 appropriate provision is made to receive and respond
15 promptly to calls received during other hours.
16 (4) LIMITS ON FREQUENCY.—Such a program
17 shall not provide for the performance of utilization
18 review activities with respect to a class of services
19 furnished to an individual more frequently than is
20 reasonably required to assess whether the services
21 under review are medically necessary or appropriate.
22 (d) DEADLINE FOR DETERMINATIONS.—
23 (1) PRIOR AUTHORIZATION SERVICES.—
24 (A) IN GENERAL.—Except as provided in
25 paragraph (2), in the case of a utilization re-

view activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B).

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for prior authorization.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

(I) receives a request for a prior authorization,

(II) determines that additional information is necessary to complete

1 the review and make the determination on the request, and
3 (III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information,
8 the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).
15 (iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for prior authorization.
20 (2) ONGOING CARE.—
21 (A) CONCURRENT REVIEW.—
22 (i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or re-

1 duction of such care, the plan must provide
2 by telephone and in printed form notice of
3 the concurrent review determination to the
4 individual or the individual's designee and
5 the individual's health care provider as
6 soon as possible in accordance with the
7 medical exigencies of the case, with suffi-
8 cient time prior to the termination or re-
9 duction to allow for an appeal under sec-
10 tion 102(c)(1)(A) to be completed before
11 the termination or reduction takes effect.
12 (ii) CONTENTS OF NOTICE.—Such no-
13 tice shall include, with respect to ongoing
14 health care items and services, the number
15 of ongoing services approved, the new total
16 of approved services, the date of onset of
17 services, and the next review date, if any,
18 as well as a statement of the individual's
19 rights to further appeal.
20 (B) EXCEPTION.—Subparagraph (A) shall
21 not be interpreted as requiring plans or issuers
22 to provide coverage of care that would exceed
23 the coverage limitations for such care.
24 (3) PREVIOUSLY PROVIDED SERVICES.—In the
25 case of a utilization review activity involving retro-

1 spective review of health care services previously pro-
2 vided for an individual, the utilization review pro-
3 gram shall make a determination concerning such
4 services, and provide notice of the determination to
5 the individual or the individual's designee and the
6 individual's health care provider by telephone and in
7 printed form, within 30 days of the date of receipt
8 of information that is reasonably necessary to make
9 such determination, but in no case later than 60
10 days after the date of receipt of the claim for bene-
11 fits.

12 (4) FAILURE TO MEET DEADLINE.—In a case
13 in which a group health plan or health insurance
14 issuer fails to make a determination on a claim for
15 benefit under paragraph (1), (2)(A), or (3) by the
16 applicable deadline established under the respective
17 paragraph, the failure shall be treated under this
18 subtitle as a denial of the claim as of the date of the
19 deadline.

20 (5) REFERENCE TO SPECIAL RULES FOR EMER-
21 GENCY SERVICES, MAINTENANCE CARE, AND POST-
22 STABILIZATION CARE.—For waiver of prior author-
23 ization requirements in certain cases involving emer-
24 gency services and maintenance care and post-sta-

1 bilization care, see subsections (a)(1) and (b) of sec-
2 tion 113, respectively.
3 (e) NOTICE OF DENIALS OF CLAIMS FOR BENE-
4 FITS.—
5 (1) IN GENERAL.—Notice of a denial of claims
6 for benefits under a utilization review program shall
7 be provided in printed form and written in a manner
8 calculated to be understood by the participant, bene-
9 ficiary, or enrollee and shall include—
10 (A) the reasons for the denial (including
11 the clinical rationale);
12 (B) instructions on how to initiate an ap-
13 peal under section 102; and
14 (C) notice of the availability, upon request
15 of the individual (or the individual's designee)
16 of the clinical review criteria relied upon to
17 make such denial.
18 (2) SPECIFICATION OF ANY ADDITIONAL INFOR-
19 MATION.—Such a notice shall also specify what (if
20 any) additional necessary information must be pro-
21 vided to, or obtained by, the person making the de-
22 nial in order to make a decision on such an appeal.
23 (f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM
24 FOR BENEFITS DEFINED.—For purposes of this subtitle:

1 (1) CLAIM FOR BENEFITS.—The term ''claim
2 for benefits'' means any request for coverage (in-
3 cluding authorization of coverage), for eligibility, or
4 for payment in whole or in part, for an item or serv-
5 ice under a group health plan or health insurance
6 coverage.

7 (2) DENIAL OF CLAIM FOR BENEFITS.—The
8 term ''denial'' means, with respect to a claim for
9 benefits, means a denial, or a failure to act on a
10 timely basis upon, in whole or in part, the claim for
11 benefits and includes a failure to provide benefits
12 (including items and services) required to be pro-
13 vided under this title.

14 **SEC. 102. INTERNAL APPEALS PROCEDURES.**

15 (a) RIGHT OF REVIEW.—

16 (1) IN GENERAL.—Each group health plan, and
17 each health insurance issuer offering health insur-
18 ance coverage—

19 (A) shall provide adequate notice in writ-
20 ing to any participant or beneficiary under such
21 plan, or enrollee under such coverage, whose
22 claim for benefits under the plan or coverage
23 has been denied (within the meaning of section
24 101(f)(2)), setting forth the specific reasons for
25 such denial of claim for benefits and rights to

1 any further review or appeal, written in a manner calculated to be understood by the participant, beneficiary, or enrollee; and

(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity (of not less than 180 days) to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in writing.

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual who—

1 (i) in a case involving medical judgment, shall be a physician or, in the case of limited scope coverage (as defined in subparagraph (B), shall be an appropriate specialist;

6 (ii) has been selected by the plan or issuer; and

8 (iii) did not make the initial denial in the internally appealable decision.

10 (B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term ''limited scope coverage'' means a group health plan or health insurance coverage the only benefits under which are for benefits described in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

17 (2) TIME LIMITS FOR INTERNAL REVIEWS.—

18 (A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, re-

1 verses, or modifies the denial. If the decision
2 does not reverse the denial, the plan or issuer
3 shall transmit, in printed form, a notice that
4 sets forth the grounds for such decision and
5 that includes a description of rights to any fur-
6 ther appeal. Such decision shall be treated as
7 the final decision of the plan. Failure to issue
8 such a decision by such deadline shall be treat-
9 ed as a final decision affirming the denial of
10 claim.

11 (B) DEADLINE.—

12 (i) IN GENERAL.—Subject to clauses
13 (ii) and (iii), the deadline specified in this
14 subparagraph is 14 days after the date of
15 receipt of the request for internal review.

16 (ii) EXTENSION PERMITTED WHERE
17 NOTICE OF ADDITIONAL INFORMATION RE-
18 QUIRED.—If a group health plan or health
19 insurance issuer—

20 (I) receives a request for internal
21 review,

22 (II) determines that additional
23 information is necessary to complete
24 the review and make the determina-
25 tion on the request, and

1 (III) notifies the requester, not
2 later than 5 business days after the
3 date of receiving the request, of the
4 need for such specified additional in-
5 formation,
6 the deadline specified in this subparagraph
7 is 14 days after the date the plan or issuer
8 receives the specified additional informa-
9 tion, but in no case later than 28 days
10 after the date of receipt of the request for
11 the internal review. This clause shall not
12 apply if the deadline is specified in clause
13 (iii).
14 (iii) EXPEDITED CASES.—In the case
15 of a situation described in subsection
16 (c)(1)(A), the deadline specified in this
17 subparagraph is 72 hours after the time of
18 the request for review.
19 (c) EXPEDITED REVIEW PROCESS.—
20 (1) IN GENERAL.—A group health plan, and a
21 health insurance issuer, shall establish procedures in
22 writing for the expedited consideration of requests
23 for review under subsection (b) in situations—
24 (A) in which, as determined by the plan or
25 issuer or as certified in writing by a treating

1 health care professional, the application of the
2 normal timeframe for making a determination
3 could seriously jeopardize the life or health of
4 the participant, beneficiary, or enrollee or such
5 an individual's ability to regain maximum func-
6 tion; or

7 (B) described in section 101(d)(2) (relat-
8 ing to requests for continuation of ongoing care
9 which would otherwise be reduced or termi-
10 nated).

11 (2) PROCESS.—Under such procedures—

12 (A) the request for expedited review may
13 be submitted orally or in writing by an indi-
14 vidual or provider who is otherwise entitled to
15 request the review;

16 (B) all necessary information, including
17 the plan's or issuer's decision, shall be trans-
18 mitted between the plan or issuer and the re-
19 quester by telephone, facsimile, or other simi-
20 larly expeditious available method; and

21 (C) the plan or issuer shall expedite the re-
22 view in the case of any of the situations de-
23 scribed in subparagraph (A) or (B) of para-
24 graph (1).

1 (3) DEADLINE FOR DECISION.—The decision on
2 the expedited review must be made and commu-
3 nicated to the parties as soon as possible in accord-
4 ance with the medical exigencies of the case, and in
5 no event later than 72 hours after the time of re-
6 ceipt of the request for expedited review, except that
7 in a case described in paragraph (1)(B), the decision
8 must be made before the end of the approved period
9 of care.

10 (d) WAIVER OF PROCESS.—A plan or issuer may
11 waive its rights for an internal review under subsection
12 (b). In such case the participant, beneficiary, or enrollee
13 involved (and any designee or provider involved) shall be
14 relieved of any obligation to complete the review involved
15 and may, at the option of such participant, beneficiary,
16 enrollee, designee, or provider, proceed directly to seek
17 further appeal through any applicable external appeals
18 process.

19 **SEC. 103. EXTERNAL APPEALS PROCEDURES.**

20 (a) RIGHT TO EXTERNAL APPEAL.—

21 (1) IN GENERAL.—A group health plan, and a
22 health insurance issuer offering health insurance
23 coverage, shall provide for an external appeals proc-
24 ess that meets the requirements of this section in
25 the case of an externally appealable decision de-

1 scribed in paragraph (2), for which a timely appeal
2 is made either by the plan or issuer or by the partic-
3 ipant, beneficiary, or enrollee (and any provider or
4 other person acting on behalf of such an individual
5 with the individual's consent or without such consent
6 if such an individual is medically unable to provide
7 such consent). The appropriate Secretary shall es-
8 tablish standards to carry out such requirements.
9 (2) EXTERNALLY APPEALABLE DECISION DE-
10 FINED.—
11 (A) IN GENERAL.—For purposes of this
12 section, the term ''externally appealable deci-
13 sion'' means a denial of claim for benefits (as
14 defined in section 101(f)(2))—
15 (i) that is based in whole or in part on
16 a decision that the item or service is not
17 medically necessary or appropriate or is in-
18 vestigational or experimental; or
19 (ii) in which the decision as to wheth-
20 er a benefit is covered involves a medical
21 judgment.
22 (B) INCLUSION.—Such term also includes
23 a failure to meet an applicable deadline for in-
24 ternal review under section 102.

1 (C) EXCLUSIONS.—Such term does not
2 include—
3 (i) specific exclusions or express limi-
4 tations on the amount, duration, or scope
5 of coverage that do not involve medical
6 judgment; or
7 (ii) a decision regarding whether an
8 individual is a participant, beneficiary, or
9 enrollee under the plan or coverage.
10 (3) EXHAUSTION OF INTERNAL REVIEW PROC-
11 ESS.—Except as provided under section 102(d), a
12 plan or issuer may condition the use of an external
13 appeal process in the case of an externally appeal-
14 able decision upon a final decision in an internal re-
15 view under section 102, but only if the decision is
16 made in a timely basis consistent with the deadlines
17 provided under this subtitle.
18 (4) FILING FEE REQUIREMENT.—
19 (A) IN GENERAL.—Subject to subpara-
20 graph (B), a plan or issuer may condition the
21 use of an external appeal process upon payment
22 to the plan or issuer of a filing fee that does
23 not exceed $25.
24 (B) EXCEPTION FOR INDIGENCY.—The
25 plan or issuer may not require payment of the

1 filing fee in the case of an individual partici-
2 pant, beneficiary, or enrollee who certifies (in a
3 form and manner specified in guidelines estab-
4 lished by the Secretary of Health and Human
5 Services) that the individual is indigent (as de-
6 fined in such guidelines).
7 (C) REFUNDING FEE IN CASE OF SUCCESS-
8 FUL APPEALS.—The plan or issuer shall refund
9 payment of the filing fee under this paragraph
10 if the recommendation of the external appeal
11 entity is to reverse or modify the denial of a
12 claim for benefits which is the subject of the
13 appeal.
14 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS
15 PROCESS.—
16 (1) CONTRACT WITH QUALIFIED EXTERNAL AP-
17 PEAL ENTITY.—
18 (A) CONTRACT REQUIREMENT.—Except as
19 provided in subparagraph (D), the external ap-
20 peal process under this section of a plan or
21 issuer shall be conducted under a contract be-
22 tween the plan or issuer and one or more quali-
23 fied external appeal entities (as defined in sub-
24 section (c)).

1 (B) LIMITATION ON PLAN OR ISSUER SE-
2 LECTION.—The applicable authority shall im-
3 plement procedures—
4 (i) to assure that the selection process
5 among qualified external appeal entities
6 will not create any incentives for external
7 appeal entities to make a decision in a bi-
8 ased manner, and
9 (ii) for auditing a sample of decisions
10 by such entities to assure that no such de-
11 cisions are made in a biased manner.
12 (C) OTHER TERMS AND CONDITIONS.—
13 The terms and conditions of a contract under
14 this paragraph shall be consistent with the
15 standards the appropriate Secretary shall estab-
16 lish to assure there is no real or apparent con-
17 flict of interest in the conduct of external ap-
18 peal activities. Such contract shall provide that
19 all costs of the process (except those incurred
20 by the participant, beneficiary, enrollee, or
21 treating professional in support of the appeal)
22 shall be paid by the plan or issuer, and not by
23 the participant, beneficiary, or enrollee. The
24 previous sentence shall not be construed as ap-

plying to the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT QUALIFIED EXTERNAL APPEAL ENTITY 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) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination. However, nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are specifically excluded under the plan or coverage.

(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's

1 or issuer's decision is in accordance with the
2 medical needs of the patient involved (as deter-
3 mined by the entity) taking into account, as of
4 the time of the entity's determination, the pa-
5 tient's medical condition and any relevant and
6 reliable evidence the entity obtains under sub-
7 paragraph (D). If the entity determines the de-
8 cision is in accordance with such needs, the en-
9 tity shall affirm the decision and to the extent
10 that the entity determines the decision is not in
11 accordance with such needs, the entity shall re-
12 verse or modify the decision.

13 (C) CONSIDERATION OF PLAN OR COV-
14 ERAGE DEFINITIONS.—In making such deter-
15 mination, the external appeal entity shall con-
16 sider (but not be bound by) any language in the
17 plan or coverage document relating to the defi-
18 nitions of the terms medical necessity, medically
19 necessary or appropriate, or experimental, in-
20 vestigational, or related terms.

21 (D) EVIDENCE.—

22 (i) IN GENERAL.—An external appeal
23 entity shall include, among the evidence
24 taken into consideration—

1 (I) the decision made by the plan
2 or issuer upon internal review under
3 section 102 and any guidelines or
4 standards used by the plan or issuer
5 in reaching such decision;
6 (II) any personal health and
7 medical information supplied with re-
8 spect to the individual whose denial of
9 claim for benefits has been appealed;
10 and
11 (III) the opinion of the individ-
12 ual's treating physician or health care
13 professional.
14 (ii) ADDITIONAL EVIDENCE.—Such
15 entity may also take into consideration but
16 not be limited to the following evidence (to
17 the extent available):
18 (I) The results of studies that
19 meet professionally recognized stand-
20 ards of validity and replicability or
21 that have been published in peer-re-
22 viewed journals.
23 (II) The results of professional
24 consensus conferences conducted or fi-

1 nanced in whole or in part by one or
2 more government agencies.
3 (III) Practice and treatment
4 guidelines prepared or financed in
5 whole or in part by government agen-
6 cies.
7 (IV) Government-issued coverage
8 and treatment policies.
9 (V) Community standard of care
10 and generally accepted principles of
11 professional medical practice.
12 (VI) To the extent that the entity
13 determines it to be free of any conflict
14 of interest, the opinions of individuals
15 who are qualified as experts in one or
16 more fields of health care which are
17 directly related to the matters under
18 appeal.
19 (VII) To the extent that the enti-
20 ty determines it to be free of any con-
21 flict of interest, the results of peer re-
22 views conducted by the plan or issuer
23 involved.

1 (E) DETERMINATION CONCERNING EXTER-
2 NALLY APPEALABLE DECISIONS.—A qualified
3 external appeal entity shall determine—
4 (i) whether a denial of claim for bene-
5 fits is an externally appealable decision
6 (within the meaning of subsection (a)(2));
7 (ii) whether an externally appealable
8 decision involves an expedited appeal; and
9 (iii) for purposes of initiating an ex-
10 ternal review, whether the internal review
11 process has been completed.
12 (F) OPPORTUNITY TO SUBMIT EVI-
13 DENCE.—Each party to an externally appeal-
14 able decision may submit evidence related to the
15 issues in dispute.
16 (G) PROVISION OF INFORMATION.—The
17 plan or issuer involved shall provide timely ac-
18 cess to the external appeal entity to information
19 and to provisions of the plan or health insur-
20 ance coverage relating to the matter of the ex-
21 ternally appealable decision, as determined by
22 the entity.
23 (H) TIMELY DECISIONS.—A determination
24 by the external appeal entity on the decision
25 shall—

1 (i) be made orally or in writing and,
2 if it is made orally, shall be supplied to the
3 parties in writing as soon as possible;
4 (ii) be made in accordance with the
5 medical exigencies of the case involved, but
6 in no event later than 21 days after the
7 date (or, in the case of an expedited ap-
8 peal, 72 hours after the time) of requesting
9 an external appeal of the decision;
10 (iii) state, in layperson's language, the
11 basis for the determination, including, if
12 relevant, any basis in the terms or condi-
13 tions of the plan or coverage; and
14 (iv) inform the participant, bene-
15 ficiary, or enrollee of the individual's rights
16 (including any limitation on such rights) to
17 seek further review by the courts (or other
18 process) of the external appeal determina-
19 tion.
20 (I) COMPLIANCE WITH DETERMINATION.—
21 If the external appeal entity reverses or modi-
22 fies the denial of a claim for benefits, the plan
23 or issuer shall—

1 (i) upon the receipt of the determina-
2 tion, authorize benefits in accordance with
3 such determination;
4 (ii) take such actions as may be nec-
5 essary to provide benefits (including items
6 or services) in a timely manner consistent
7 with such determination; and
8 (iii) submit information to the entity
9 documenting compliance with the entity's
10 determination and this subparagraph.
11 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-
12 TIES.—
13 (1) IN GENERAL.—For purposes of this section,
14 the term "qualified external appeal entity" means,
15 in relation to a plan or issuer, an entity that is cer-
16 tified under paragraph (2) as meeting the following
17 requirements:
18 (A) The entity meets the independence re-
19 quirements of paragraph (3).
20 (B) The entity conducts external appeal
21 activities through a panel of not fewer than 3
22 clinical peers.
23 (C) The entity has sufficient medical, legal,
24 and other expertise and sufficient staffing to
25 conduct external appeal activities for the plan

1 or issuer on a timely basis consistent with sub-
2 section (b)(2)(G).
3 (D) The entity meets such other require-
4 ments as the appropriate Secretary may im-
5 pose.
6 (2) INITIAL CERTIFICATION OF EXTERNAL AP-
7 PEAL ENTITIES.—
8 (A) IN GENERAL.—In order to be treated
9 as a qualified external appeal entity with re-
10 spect to—
11 (i) a group health plan, the entity
12 must be certified (and, in accordance with
13 subparagraph (B), periodically recertified)
14 as meeting the requirements of paragraph
15 (1)—
16 (I) by the Secretary of Labor;
17 (II) under a process recognized
18 or approved by the Secretary of
19 Labor; or
20 (III) to the extent provided in
21 subparagraph (C)(i), by a qualified
22 private standard-setting organization
23 (certified under such subparagraph);
24 or

1 (ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

(I) by the applicable State authority (or under a process recognized or approved by such authority); or

(II) if the State has not established a certification and recertification process for such entities, by the Secretary of Health and Human Services, under a process recognized or approved by such Secretary, or to the extent provided in subparagraph (C)(ii), by a qualified private standard-setting organization (certified under such subparagraph).

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

(i) the number of cases reviewed;

(ii) a summary of the disposition of those cases;

1 (iii) the length of time in making de-
2 terminations on those cases;
3 (iv) updated information of what was
4 required to be submitted as a condition of
5 certification for the entity's performance of
6 external appeal activities; and
7 (v) such information as may be nec-
8 essary to assure the independence of the
9 entity from the plans or issuers for which
10 external appeal activities are being con-
11 ducted.
12 (C) CERTIFICATION OF QUALIFIED PRI-
13 VATE STANDARD-SETTING ORGANIZATIONS.—
14 (i) FOR EXTERNAL REVIEWS UNDER
15 GROUP HEALTH PLANS.—For purposes of
16 subparagraph (A)(i)(III), the Secretary of
17 Labor may provide for a process for certifi-
18 cation (and periodic recertification) of
19 qualified private standard-setting organiza-
20 tions which provide for certification of ex-
21 ternal review entities. Such an organization
22 shall only be certified if the organization
23 does not certify an external review entity
24 unless it meets standards required for cer-

1 tification of such an entity by such Sec-
2 retary under subparagraph (A)(i)(I).
3 (ii) FOR EXTERNAL REVIEWS OF
4 HEALTH INSURANCE ISSUERS.—For pur-
5 poses of subparagraph (A)(ii)(II), the Sec-
6 retary of Health and Human Services may
7 provide for a process for certification (and
8 periodic recertification) of qualified private
9 standard-setting organizations which pro-
10 vide for certification of external review en-
11 tities. Such an organization shall only be
12 certified if the organization does not certify
13 an external review entity unless it meets
14 standards required for certification of such
15 an entity by such Secretary under subpara-
16 graph (A)(ii)(II).
17 (3) INDEPENDENCE REQUIREMENTS.—
18 (A) IN GENERAL.—A clinical peer or other
19 entity meets the independence requirements of
20 this paragraph if—
21 (i) the peer or entity does not have a
22 familial, financial, or professional relation-
23 ship with any related party;
24 (ii) any compensation received by such
25 peer or entity in connection with the exter-

1 nal review is reasonable and not contingent
2 on any decision rendered by the peer or en-
3 tity;
4 (iii) except as provided in paragraph
5 (4), the plan and the issuer have no re-
6 course against the peer or entity in connec-
7 tion with the external review; and
8 (iv) the peer or entity does not other-
9 wise have a conflict of interest with a re-
10 lated party as determined under any regu-
11 lations which the Secretary may prescribe.
12 (B) RELATED PARTY.—For purposes of
13 this paragraph, the term ''related party''
14 means—
15 (i) with respect to—
16 (I) a group health plan or health
17 insurance coverage offered in connec-
18 tion with such a plan, the plan or the
19 health insurance issuer offering such
20 coverage, or
21 (II) individual health insurance
22 coverage, the health insurance issuer
23 offering such coverage,

1 or any plan sponsor, fiduciary, officer, di-
2 rector, or management employee of such
3 plan or issuer;
4 (ii) the health care professional that
5 provided the health care involved in the
6 coverage decision;
7 (iii) the institution at which the health
8 care involved in the coverage decision is
9 provided;
10 (iv) the manufacturer of any drug or
11 other item that was included in the health
12 care involved in the coverage decision; or
13 (v) any other party determined under
14 any regulations which the Secretary may
15 prescribe to have a substantial interest in
16 the coverage decision.
17 (4) LIMITATION ON LIABILITY OF REVIEW-
18 ERS.—No qualified external appeal entity having a
19 contract with a plan or issuer under this part and
20 no person who is employed by any such entity or
21 who furnishes professional services to such entity,
22 shall be held by reason of the performance of any
23 duty, function, or activity required or authorized
24 pursuant to this section, to have violated any crimi-
25 nal law, or to be civilly liable under any law of the

1 United States or of any State (or political subdivi-
2 sion thereof) if due care was exercised in the per-
3 formance of such duty, function, or activity and
4 there was no actual malice or gross misconduct in
5 the performance of such duty, function, or activity.
6 (d) EXTERNAL APPEAL DETERMINATION BINDING
7 ON PLAN.—The determination by an external appeal enti-
8 ty under this section is binding on the plan and issuer
9 involved in the determination.
10 (e) PENALTIES AGAINST AUTHORIZED OFFICIALS
11 FOR REFUSING TO AUTHORIZE THE DETERMINATION OF
12 AN EXTERNAL REVIEW ENTITY.—
13 (1) MONETARY PENALTIES.—In any case in
14 which the determination of an external review entity
15 is not followed by a group health plan, or by a
16 health insurance issuer offering health insurance
17 coverage, any person who, acting in the capacity of
18 authorizing the benefit, causes such refusal may, in
19 the discretion in a court of competent jurisdiction,
20 be liable to an aggrieved participant, beneficiary, or
21 enrollee for a civil penalty in an amount of up to
22 $1,000 a day from the date on which the determina-
23 tion was transmitted to the plan or issuer by the ex-
24 ternal review entity until the date the refusal to pro-
25 vide the benefit is corrected.

1 (2) CEASE AND DESIST ORDER AND ORDER OF
2 ATTORNEY'S FEES.—In any action described in
3 paragraph (1) brought by a participant, beneficiary,
4 or enrollee with respect to a group health plan, or
5 a health insurance issuer offering health insurance
6 coverage, in which a plaintiff alleges that a person
7 referred to in such paragraph has taken an action
8 resulting in a refusal of a benefit determined by an
9 external appeal entity in violation of such terms of
10 the plan, coverage, or this subtitle, or has failed to
11 take an action for which such person is responsible
12 under the plan, coverage, or this title and which is
13 necessary under the plan or coverage for authorizing
14 a benefit, the court shall cause to be served on the
15 defendant an order requiring the defendant—
16 (A) to cease and desist from the alleged
17 action or failure to act; and
18 (B) to pay to the plaintiff a reasonable at-
19 torney's fee and other reasonable costs relating
20 to the prosecution of the action on the charges
21 on which the plaintiff prevails.
22 (3) ADDITIONAL CIVIL PENALTIES.—
23 (A) IN GENERAL.—In addition to any pen-
24 alty imposed under paragraph (1) or (2), the
25 appropriate Secretary may assess a civil penalty

1 against a person acting in the capacity of au-
2 thorizing a benefit determined by an external
3 review entity for one or more group health
4 plans, or health insurance issuers offering
5 health insurance coverage, for—
6 (i) any pattern or practice of repeated
7 refusal to authorize a benefit determined
8 by an external appeal entity in violation of
9 the terms of such a plan, coverage, or this
10 title; or
11 (ii) any pattern or practice of re-
12 peated violations of the requirements of
13 this section with respect to such plan or
14 plans or coverage.
15 (B) STANDARD OF PROOF AND AMOUNT OF
16 PENALTY.—Such penalty shall be payable only
17 upon proof by clear and convincing evidence of
18 such pattern or practice and shall be in an
19 amount not to exceed the lesser of—
20 (i) 25 percent of the aggregate value
21 of benefits shown by the appropriate Sec-
22 retary to have not been provided, or unlaw-
23 fully delayed, in violation of this section
24 under such pattern or practice, or
25 (ii) $500,000.

1 (4) REMOVAL AND DISQUALIFICATION.—Any
2 person acting in the capacity of authorizing benefits
3 who has engaged in any such pattern or practice de-
4 scribed in paragraph (3)(A) with respect to a plan
5 or coverage, upon the petition of the appropriate
6 Secretary, may be removed by the court from such
7 position, and from any other involvement, with re-
8 spect to such a plan or coverage, and may be pre-
9 cluded from returning to any such position or in-
10 volvement for a period determined by the court.
11 (f) PROTECTION OF LEGAL RIGHTS.—Nothing in
12 this subtitle shall be construed as altering or eliminating
13 any cause of action or legal rights or remedies of partici-
14 pants, beneficiaries, enrollees, and others under State or
15 Federal law (including sections 502 and 503 of the Em-
16 ployee Retirement Income Security Act of 1974), includ-
17 ing the right to file judicial actions to enforce actions.

18 **SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.**

19 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—
20 (1) IN GENERAL.—A group health plan, and a
21 health insurance issuer in connection with the provi-
22 sion of health insurance coverage, shall establish and
23 maintain a system to provide for the presentation
24 and resolution of oral and written grievances
25 brought by individuals who are participants, bene-

1 ficiaries, or enrollees, or health care providers or
2 other individuals acting on behalf of an individual
3 and with the individual's consent or without such
4 consent if the individual is medically unable to pro-
5 vide such consent, regarding any aspect of the plan's
6 or issuer's services.

7 (2) GRIEVANCE DEFINED.—In this section, the
8 term ''grievance'' means any question, complaint, or
9 concern brought by a participant, beneficiary or en-
10 rollee that is not a claim for benefits (as defined in
11 section 101(f)(1)).

12 (b) GRIEVANCE SYSTEM.—Such system shall include
13 the following components with respect to individuals who
14 are participants, beneficiaries, or enrollees:

15 (1) Written notification to all such individuals
16 and providers of the telephone numbers and business
17 addresses of the plan or issuer personnel responsible
18 for resolution of grievances and appeals.

19 (2) A system to record and document, over a
20 period of at least 3 previous years, all grievances
21 and appeals made and their status.

22 (3) A process providing for timely processing
23 and resolution of grievances.

(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subtitle.

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides 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 issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees 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 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 unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. 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 or appropriate specialty care, pursu-

1 ant to appropriate referral procedures, from any
2 qualified participating health care professional who
3 is available to accept such individual for such care.
4 (2) LIMITATION.—Paragraph (1) shall not
5 apply to specialty care if the plan or issuer clearly
6 informs participants, beneficiaries, and enrollees of
7 the limitations on choice of participating health care
8 professionals with respect to such care.

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

10 (a) COVERAGE OF EMERGENCY SERVICES.—
11 (1) IN GENERAL.—If a group health plan, or
12 health insurance coverage offered by a health insur-
13 ance issuer, provides any benefits with respect to
14 services in an emergency department of a hospital,
15 the plan or issuer shall cover emergency services (as
16 defined in paragraph (2)(B))—
17 (A) without the need for any prior author-
18 ization determination;
19 (B) whether or not the health care pro-
20 vider furnishing such services is a participating
21 provider with respect to such services;
22 (C) in a manner so that, if such services
23 are provided to a participant, beneficiary, or
24 enrollee—

1 (i) by a nonparticipating health care
2 provider with or without prior authoriza-
3 tion, or
4 (ii) by a participating health care pro-
5 vider without prior authorization,
6 the participant, beneficiary, or enrollee is not
7 liable for amounts that exceed the amounts of
8 liability that would be incurred if the services
9 were provided by a participating health care
10 provider with prior authorization; and
11 (D) without regard to any other term or
12 condition of such coverage (other than exclusion
13 or coordination of benefits, or an affiliation or
14 waiting period, permitted under section 2701 of
15 the Public Health Service Act, section 701 of
16 the Employee Retirement Income Security Act
17 of 1974, or section 9801 of the Internal Rev-
18 enue Code of 1986, and other than applicable
19 cost-sharing).
20 (2) DEFINITIONS.—In this section:
21 (A) EMERGENCY MEDICAL CONDITION
22 BASED ON PRUDENT LAYPERSON STANDARD.—
23 The term ''emergency medical condition'' means
24 a medical condition manifesting itself by acute
25 symptoms of sufficient severity (including se-

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

8 (B) EMERGENCY SERVICES.—The term
9 ''emergency services'' means—

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

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

24 (C) STABILIZE.—The term ''to stabilize''
25 means, with respect to an emergency medical

1 condition, to provide such medical treatment of
2 the condition as may be necessary to assure,
3 within reasonable medical probability, that no
4 material deterioration of the condition is likely
5 to result from or occur during the transfer of
6 the individual from a facility.

7 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND
8 POST-STABILIZATION CARE.—If benefits are available
9 under a group health plan, or under health insurance cov-
10 erage offered by a health insurance issuer, with respect
11 to maintenance care or post-stabilization care covered
12 under the guidelines established under section 1852(d)(2)
13 of the Social Security Act, the plan or issuer shall provide
14 for reimbursement with respect to such services provided
15 to a participant, beneficiary, or enrollee other than
16 through a participating health care provider in a manner
17 consistent with subsection (a)(1)(C) (and shall otherwise
18 comply with such guidelines).

19 **SEC. 114. ACCESS TO SPECIALTY CARE.**

20 (a) SPECIALTY CARE FOR COVERED SERVICES.—
21 (1) IN GENERAL.—If—
22 (A) an individual is a participant or bene-
23 ficiary under a group health plan or an enrollee
24 who is covered under health insurance coverage
25 offered by a health insurance issuer,

1 (B) the individual has a condition or dis-
2 ease of sufficient seriousness and complexity to
3 require treatment by a specialist, and
4 (C) benefits for such treatment are pro-
5 vided under the plan or coverage,
6 the plan or issuer shall make or provide for a refer-
7 ral to a specialist who is available and accessible to
8 provide the treatment for such condition or disease.
9 (2) SPECIALIST DEFINED.—For purposes of
10 this subsection, the term ''specialist'' means, with
11 respect to a condition, a health care practitioner, fa-
12 cility, or center that has adequate expertise through
13 appropriate training and experience (including, in
14 the case of a child, appropriate pediatric expertise)
15 to provide high quality care in treating the condi-
16 tion.
17 (3) CARE UNDER REFERRAL.—A group health
18 plan or health insurance issuer may require that the
19 care provided to an individual pursuant to such re-
20 ferral under paragraph (1) be—
21 (A) pursuant to a treatment plan, only if
22 the treatment plan is developed by the specialist
23 and approved by the plan or issuer, in consulta-
24 tion with the designated primary care provider

1 or specialist and the individual (or the individ-
2 ual's designee), and
3 (B) in accordance with applicable quality
4 assurance and utilization review standards of
5 the plan or issuer.
6 Nothing in this subsection shall be construed as pre-
7 venting such a treatment plan for an individual from
8 requiring a specialist to provide the primary care
9 provider with regular updates on the specialty care
10 provided, as well as all necessary medical informa-
11 tion.
12 (4) REFERRALS TO PARTICIPATING PRO-
13 VIDERS.—A group health plan or health insurance
14 issuer is not required under paragraph (1) to pro-
15 vide for a referral to a specialist that is not a par-
16 ticipating provider, unless the plan or issuer does
17 not have an appropriate specialist that is available
18 and accessible to treat the individual's condition and
19 that is a participating provider with respect to such
20 treatment.
21 (5) TREATMENT OF NONPARTICIPATING PRO-
22 VIDERS.—If a plan or issuer refers an individual to
23 a nonparticipating specialist pursuant to paragraph
24 (1), services provided pursuant to the approved
25 treatment plan (if any) shall be provided at no addi-

1 tional cost to the individual beyond what the indi-
2 vidual would otherwise pay for services received by
3 such a specialist that is a participating provider.
4 (b) SPECIALISTS AS GATEKEEPER FOR TREATMENT
5 OF ONGOING SPECIAL CONDITIONS.—
6 (1) IN GENERAL.—A group health plan, or a
7 health insurance issuer, in connection with the provi-
8 sion of health insurance coverage, shall have a proce-
9 dure by which an individual who is a participant,
10 beneficiary, or enrollee and who has an ongoing spe-
11 cial condition (as defined in paragraph (3)) may re-
12 quest and receive a referral to a specialist for such
13 condition who shall be responsible for and capable of
14 providing and coordinating the individual's care with
15 respect to the condition. Under such procedures if
16 such an individual's care would most appropriately
17 be coordinated by such a specialist, such plan or
18 issuer shall refer the individual to such specialist.
19 (2) TREATMENT FOR RELATED REFERRALS.—
20 Such specialists shall be permitted to treat the indi-
21 vidual without a referral from the individual's pri-
22 mary care provider and may authorize such refer-
23 rals, procedures, tests, and other medical services as
24 the individual's primary care provider would other-
25 wise be permitted to provide or authorize, subject to

1 the terms of the treatment (referred to in subsection
2 (a)(3)(A)) with respect to the ongoing special condi-
3 tion.
4 (3) ONGOING SPECIAL CONDITION DEFINED.—
5 In this subsection, the term "ongoing special condi-
6 tion" means a condition or disease that—
7 (A) is life-threatening, degenerative, or dis-
8 abling, and
9 (B) requires specialized medical care over
10 a prolonged period of time.
11 (4) TERMS OF REFERRAL.—The provisions of
12 paragraphs (3) through (5) of subsection (a) apply
13 with respect to referrals under paragraph (1) of this
14 subsection in the same manner as they apply to re-
15 ferrals under subsection (a)(1).
16 (c) STANDING REFERRALS.—
17 (1) IN GENERAL.—A group health plan, and a
18 health insurance issuer in connection with the provi-
19 sion of health insurance coverage, shall have a proce-
20 dure by which an individual who is a participant,
21 beneficiary, or enrollee and who has a condition that
22 requires ongoing care from a specialist may receive
23 a standing referral to such specialist for treatment
24 of such condition. If the plan or issuer, or if the pri-
25 mary care provider in consultation with the medical

1 director of the plan or issuer and the specialist (if
2 any), determines that such a standing referral is ap-
3 propriate, the plan or issuer shall make such a refer-
4 ral to such a specialist if the individual so desires.
5 (2) TERMS OF REFERRAL.—The provisions of
6 paragraphs (3) through (5) of subsection (a) apply
7 with respect to referrals under paragraph (1) of this
8 subsection in the same manner as they apply to re-
9 ferrals under subsection (a)(1).

10 **SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL**
11 **CARE.**

12 (a) IN GENERAL.—If a group health plan, or a health
13 insurance issuer in connection with the provision of health
14 insurance coverage, requires or provides for a participant,
15 beneficiary, or enrollee to designate a participating pri-
16 mary care health care professional, the plan or issuer—
17 (1) may not require authorization or a referral
18 by the individual's primary care health care profes-
19 sional or otherwise for coverage of gynecological care
20 (including preventive women's health examinations)
21 and pregnancy-related services provided by a partici-
22 pating health care professional, including a physi-
23 cian, who specializes in obstetrics and gynecology to
24 the extent such care is otherwise covered, and

1 (2) shall treat the ordering of other obstetrical
2 or gynecological care by such a participating profes-
3 sional as the authorization of the primary care
4 health care professional with respect to such care
5 under the plan or coverage.
6 (b) CONSTRUCTION.—Nothing in subsection (a) shall
7 be construed to—
8 (1) waive any exclusions of coverage under the
9 terms of the plan or health insurance coverage with
10 respect to coverage of obstetrical or gynecological
11 care; or
12 (2) preclude the group health plan or health in-
13 surance issuer involved from requiring that the ob-
14 stetrical or gynecological provider notify the primary
15 care health care professional or the plan or issuer of
16 treatment decisions.

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

18 (a) PEDIATRIC CARE.—If a group health plan, or a
19 health insurance issuer in connection with the provision
20 of health insurance coverage, requires or provides for an
21 enrollee to designate a participating primary care provider
22 for a child of such enrollee, the plan or issuer shall permit
23 the enrollee to designate a physician who specializes in pe-
24 diatrics as the child's primary care provider.

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

5 **SEC. 117. CONTINUITY OF CARE.**

6 (a) IN GENERAL.—
7 (1) TERMINATION OF PROVIDER.—If a contract
8 between a group health plan, or a health insurance
9 issuer in connection with the provision of health in-
10 surance coverage, and a health care provider is ter-
11 minated (as defined in paragraph (3)(B)), or bene-
12 fits or coverage provided by a health care provider
13 are terminated because of a change in the terms of
14 provider participation in a group health plan, and an
15 individual who is a participant, beneficiary, or en-
16 rollee in the plan or coverage is undergoing treat-
17 ment from the provider for an ongoing special condi-
18 tion (as defined in paragraph (3)(A)) at the time of
19 such termination, the plan or issuer shall—
20 (A) notify the individual on a timely basis
21 of such termination and of the right to elect
22 continuation of coverage of treatment by the
23 provider under this section; and
24 (B) subject to subsection (c), permit the
25 individual to elect to continue to be covered

1 with respect to treatment by the provider of
2 such condition during a transitional period
3 (provided under subsection (b)).
4 (2) TREATMENT OF TERMINATION OF CON-
5 TRACT WITH HEALTH INSURANCE ISSUER.—If a
6 contract for the provision of health insurance cov-
7 erage between a group health plan and a health in-
8 surance issuer is terminated and, as a result of such
9 termination, coverage of services of a health care
10 provider is terminated with respect to an individual,
11 the provisions of paragraph (1) (and the succeeding
12 provisions of this section) shall apply under the plan
13 in the same manner as if there had been a contract
14 between the plan and the provider that had been ter-
15 minated, but only with respect to benefits that are
16 covered under the plan after the contract termi-
17 nation.
18 (3) DEFINITIONS.—For purposes of this sec-
19 tion:
20 (A) ONGOING SPECIAL CONDITION.—The
21 term ''ongoing special condition'' has the mean-
22 ing given such term in section 114(b)(3), and
23 also includes pregnancy.
24 (B) TERMINATION.—The term ''termi-
25 nated'' includes, with respect to a contract, the

1 expiration or nonrenewal of the contract, but
2 does not include a termination of the contract
3 by the plan or issuer for failure to meet applica-
4 ble quality standards or for fraud.
5 (b) TRANSITIONAL PERIOD.—
6 (1) IN GENERAL.—Except as provided in para-
7 graphs (2) through (4), the transitional period under
8 this subsection shall extend up to 90 days (as deter-
9 mined by the treating health care professional) after
10 the date of the notice described in subsection
11 (a)(1)(A) of the provider's termination.
12 (2) SCHEDULED SURGERY AND ORGAN TRANS-
13 PLANTATION.—If surgery or organ transplantation
14 was scheduled for an individual before the date of
15 the announcement of the termination of the provider
16 status under subsection (a)(1)(A) or if the individual
17 on such date was on an established waiting list or
18 otherwise scheduled to have such surgery or trans-
19 plantation, the transitional period under this sub-
20 section with respect to the surgery or transplan-
21 tation shall extend beyond the period under para-
22 graph (1) and until the date of discharge of the indi-
23 vidual after completion of the surgery or transplan-
24 tation.
25 (3) PREGNANCY.—If—

1 (A) a participant, beneficiary, or enrollee
2 was determined to be pregnant at the time of
3 a provider's termination of participation, and
4 (B) the provider was treating the preg-
5 nancy before date of the termination,
6 the transitional period under this subsection with re-
7 spect to provider's treatment of the pregnancy shall
8 extend through the provision of post-partum care di-
9 rectly related to the delivery.
10 (4) TERMINAL ILLNESS.—If—
11 (A) a participant, beneficiary, or enrollee
12 was determined to be terminally ill (as deter-
13 mined under section 1861(dd)(3)(A) of the So-
14 cial Security Act) at the time of a provider's
15 termination of participation, and
16 (B) the provider was treating the terminal
17 illness before the date of termination,
18 the transitional period under this subsection shall
19 extend for the remainder of the individual's life for
20 care directly related to the treatment of the terminal
21 illness or its medical manifestations.
22 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
23 group health plan or health insurance issuer may condi-
24 tion coverage of continued treatment by a provider under
25 subsection (a)(1)(B) upon the individual notifying the plan

1 of the election of continued coverage and upon the pro-
2 vider agreeing to the following terms and conditions:
3 (1) The provider agrees to accept reimburse-
4 ment from the plan or issuer and individual involved
5 (with respect to cost-sharing) at the rates applicable
6 prior to the start of the transitional period as pay-
7 ment in full (or, in the case described in subsection
8 (a)(2), at the rates applicable under the replacement
9 plan or issuer after the date of the termination of
10 the contract with the health insurance issuer) and
11 not to impose cost-sharing with respect to the indi-
12 vidual in an amount that would exceed the cost-shar-
13 ing that could have been imposed if the contract re-
14 ferred to in subsection (a)(1) had not been termi-
15 nated.
16 (2) The provider agrees to adhere to the quality
17 assurance standards of the plan or issuer responsible
18 for payment under paragraph (1) and to provide to
19 such plan or issuer necessary medical information
20 related to the care provided.
21 (3) The provider agrees otherwise to adhere to
22 such plan's or issuer's policies and procedures, in-
23 cluding procedures regarding referrals and obtaining
24 prior authorization and providing services pursuant

to a treatment plan (if any) approved by the plan or issuer.

(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(1) ensure participation of participating physicians and pharmacists in the development of the formulary;

(2) disclose to providers and, disclose upon request under section 121(c)(5) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 101, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

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

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

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

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

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

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

22 (2) Either—

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

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

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

10 (c) PAYMENT.—

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

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

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

22 (B) a nonparticipating provider, the pay-
23 ment rate shall be at the rate the plan or issuer
24 would normally pay for comparable services
25 under subparagraph (A).

1 (d) APPROVED CLINICAL TRIAL DEFINED.—
2 (1) IN GENERAL.—In this section, the term
3 ''approved clinical trial'' means a clinical research
4 study or clinical investigation approved and funded
5 (which may include funding through in-kind con-
6 tributions) by one or more of the following:
7 (A) The National Institutes of Health.
8 (B) A cooperative group or center of the
9 National Institutes of Health.
10 (C) Either of the following if the condi-
11 tions described in paragraph (2) are met:
12 (i) The Department of Veterans Af-
13 fairs.
14 (ii) The Department of Defense.
15 (2) CONDITIONS FOR DEPARTMENTS.—The
16 conditions described in this paragraph, for a study
17 or investigation conducted by a Department, are
18 that the study or investigation has been reviewed
19 and approved through a system of peer review that
20 the Secretary determines—
21 (A) to be comparable to the system of peer
22 review of studies and investigations used by the
23 National Institutes of Health, and

(B) assures unbiased review of the highest scientific 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.

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

1 (C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) or (c) in printed form.

6 (2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

9 (A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b) in printed form;

13 (B) provide to enrollees, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

19 (C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c) in printed form.

24 (b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health

plan or health insurance coverage offered by a health insurance issuer includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) covered benefits, including benefit limits and coverage exclusions;

(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

1 (3) ACCESS.—A description of the following:
2 (A) The number, mix, and distribution of
3 providers under the plan or coverage.
4 (B) Out-of-network coverage (if any) pro-
5 vided by the plan or coverage.
6 (C) Any point-of-service option (including
7 any supplemental premium or cost-sharing for
8 such option).
9 (D) The procedures for participants, bene-
10 ficiaries, and enrollees to select, access, and
11 change participating primary and specialty pro-
12 viders.
13 (E) The rights and procedures for obtain-
14 ing referrals (including standing referrals) to
15 participating and nonparticipating providers.
16 (F) The name, address, and telephone
17 number of participating health care providers
18 and an indication of whether each such provider
19 is available to accept new patients.
20 (G) Any limitations imposed on the selec-
21 tion of qualifying participating health care pro-
22 viders, including any limitations imposed under
23 section 112(b)(2).
24 (H) How the plan or issuer addresses the
25 needs of participants, beneficiaries, and enroll-

1 ees and others who do not speak English or
2 who have other special communications needs in
3 accessing providers under the plan or coverage,
4 including the provision of information described
5 in this subsection and subsection (c) to such in-
6 dividuals.
7 (4) OUT-OF-AREA COVERAGE.—Out-of-area cov-
8 erage provided by the plan or issuer.
9 (5) EMERGENCY COVERAGE.—Coverage of
10 emergency services, including—
11 (A) the appropriate use of emergency serv-
12 ices, including use of the 911 telephone system
13 or its local equivalent in emergency situations
14 and an explanation of what constitutes an
15 emergency situation;
16 (B) the process and procedures of the plan
17 or issuer for obtaining emergency services; and
18 (C) the locations of (i) emergency depart-
19 ments, and (ii) other settings, in which plan
20 physicians and hospitals provide emergency
21 services and post-stabilization care.
22 (6) PERCENTAGE OF PREMIUMS USED FOR
23 BENEFITS (LOSS-RATIOS).—In the case of health in-
24 surance coverage only (and not with respect to group
25 health plans that do not provide coverage through

1 health insurance coverage), a description of the over-
2 all loss-ratio for the coverage (as defined in accord-
3 ance with rules established or recognized by the Sec-
4 retary of Health and Human Services).

5 (7) PRIOR AUTHORIZATION RULES.—Rules re-
6 garding prior authorization or other review require-
7 ments that could result in noncoverage or non-
8 payment.

9 (8) GRIEVANCE AND APPEALS PROCEDURES.—
10 All appeal or grievance rights and procedures under
11 the plan or coverage, including the method for filing
12 grievances and the time frames and circumstances
13 for acting on grievances and appeals, who is the ap-
14 plicable authority with respect to the plan or issuer.

15 (9) QUALITY ASSURANCE.—Any information
16 made public by an accrediting organization in the
17 process of accreditation of the plan or issuer or any
18 additional quality indicators the plan or issuer
19 makes available.

20 (10) INFORMATION ON ISSUER.—Notice of ap-
21 propriate mailing addresses and telephone numbers
22 to be used by participants, beneficiaries, and enroll-
23 ees in seeking information or authorization for treat-
24 ment.

1 (11) NOTICE OF REQUIREMENTS.—Notice of
2 the requirements of this title.
3 (12) AVAILABILITY OF INFORMATION ON RE-
4 QUEST.—Notice that the information described in
5 subsection (c) is available upon request.
6 (c) INFORMATION MADE AVAILABLE UPON RE-
7 QUEST.—The information described in this subsection is
8 the following:
9 (1) UTILIZATION REVIEW ACTIVITIES.—A de-
10 scription of procedures used and requirements (in-
11 cluding circumstances, time frames, and appeal
12 rights) under any utilization review program under
13 section 101, including under any drug formulary
14 program under section 118.
15 (2) GRIEVANCE AND APPEALS INFORMATION.—
16 Information on the number of grievances and ap-
17 peals and on the disposition in the aggregate of such
18 matters.
19 (3) METHOD OF PHYSICIAN COMPENSATION.—
20 A general description by category (including salary,
21 fee-for-service, capitation, and such other categories
22 as may be specified in regulations of the Secretary)
23 of the applicable method by which a specified pro-
24 spective or treating health care professional is (or

would be) compensated in connection with the provision of health care under the plan or coverage.

(4) SPECIFIC INFORMATION ON CREDENTIALS OF PARTICIPATING PROVIDERS.—In the case of each participating provider, a description of the credentials of the provider.

(5) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

(6) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

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 pro-

1 viders) shall not prohibit or otherwise restrict a health
2 care professional from advising such a participant, bene-
3 ficiary, or enrollee who is a patient of the professional
4 about the health status of the individual or medical care
5 or treatment for the individual's condition or disease, re-
6 gardless of whether benefits for such care or treatment
7 are provided under the plan or coverage, if the professional
8 is acting within the lawful scope of practice.

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

12 **SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PRO-**
13 **VIDERS BASED ON LICENSURE.**

14 (a) IN GENERAL.—A group health plan and a health
15 insurance issuer offering health insurance coverage shall
16 not discriminate with respect to participation or indem-
17 nification as to any provider who is acting within the scope
18 of the provider's license or certification under applicable
19 State law, solely on the basis of such license or certifi-
20 cation.

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

23 (1) as requiring the coverage under a group
24 health plan or health insurance coverage of par-
25 ticular benefits or services or to prohibit a plan or

1 issuer from including providers only to the extent
2 necessary to meet the needs of the plan's or issuer's
3 participants, beneficiaries, or enrollees or from es-
4 tablishing any measure designed to maintain quality
5 and control costs consistent with the responsibilities
6 of the plan or issuer;
7 (2) to override any State licensure or scope-of-
8 practice law; or
9 (3) as requiring a plan or issuer that offers net-
10 work coverage to include for participation every will-
11 ing provider who meets the terms and conditions of
12 the plan or issuer.

13 **SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE**
14 **ARRANGEMENTS.**

15 (a) IN GENERAL.—A group health plan and a health
16 insurance issuer offering health insurance coverage may
17 not operate any physician incentive plan (as defined in
18 subparagraph (B) of section 1876(i)(8) of the Social Secu-
19 rity Act) unless the requirements described in clauses (i),
20 (ii)(I), and (iii) of subparagraph (A) of such section are
21 met with respect to such a plan.
22 (b) APPLICATION.—For purposes of carrying out
23 paragraph (1), any reference in section 1876(i)(8) of the
24 Social Security Act to the Secretary, an eligible organiza-
25 tion, or an individual enrolled with the organization shall

1 be treated as a reference to the applicable authority, a
2 group health plan or health insurance issuer, respectively,
3 and a participant, beneficiary, or enrollee with the plan
4 or organization, respectively.

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

8 **SEC. 134. PAYMENT OF CLAIMS.**

9 A group health plan, and a health insurance issuer
10 offering group health insurance coverage, shall provide for
11 prompt payment of claims submitted for health care serv-
12 ices or supplies furnished to a participant, beneficiary, or
13 enrollee with respect to benefits covered by the plan or
14 issuer, in a manner consistent with the provisions of sec-
15 tions 1816(c)(2) and 1842(c)(2) of the Social Security Act
16 (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), ex-
17 cept that for purposes of this section, subparagraph (C)
18 of section 1816(c)(2) of the Social Security Act shall be
19 treated as applying to claims received from a participant,
20 beneficiary, or enrollee as well as claims referred to in
21 such subparagraph.

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

23 (a) PROTECTION FOR USE OF UTILIZATION REVIEW
24 AND GRIEVANCE PROCESS.—A group health plan, and a
25 health insurance issuer with respect to the provision of

1 health insurance coverage, may not retaliate against a par-
2 ticipant, beneficiary, enrollee, or health care provider
3 based on the participant's, beneficiary's, enrollee's or pro-
4 vider's use of, or participation in, a utilization review proc-
5 ess or a grievance process of the plan or issuer (including
6 an internal or external review or appeal process) under
7 this title.

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

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

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

21 (B) initiates, cooperates, or otherwise par-
22 ticipates in an investigation or proceeding by
23 such an agency with respect to such care, serv-
24 ices, or conditions.

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

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

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

1 (B) the professional reasonably believes the
2 information to be true;
3 (C) the information evidences either a vio-
4 lation of a law, rule, or regulation, of an appli-
5 cable accreditation standard, or of a generally
6 recognized professional or clinical standard or
7 that a patient is in imminent hazard of loss of
8 life or serious injury; and
9 (D) subject to subparagraphs (B) and (C)
10 of paragraph (3), the professional has followed
11 reasonable internal procedures of the plan,
12 issuer, or institutional health care provider es-
13 tablished for the purpose of addressing quality
14 concerns before making the disclosure.
15 (3) EXCEPTION AND SPECIAL RULE.—
16 (A) GENERAL EXCEPTION.—Paragraph (1)
17 does not protect disclosures that would violate
18 Federal or State law or diminish or impair the
19 rights of any person to the continued protection
20 of confidentiality of communications provided
21 by such law.
22 (B) NOTICE OF INTERNAL PROCEDURES.—
23 Subparagraph (D) of paragraph (2) shall not
24 apply unless the internal procedures involved
25 are reasonably expected to be known to the

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

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

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

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

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

23 (4) ADDITIONAL CONSIDERATIONS.—It shall
24 not be a violation of paragraph (1) to take an ad-
25 verse action against a protected health care profes-

1 sional if the plan, issuer, or provider taking the ad-
2 verse action involved demonstrates that it would
3 have taken the same adverse action even in the ab-
4 sence of the activities protected under such para-
5 graph.

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

13 (6) CONSTRUCTIONS.—

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

20 (B) ENFORCEMENT OF PEER REVIEW PRO-
21 TOCOLS AND INTERNAL PROCEDURES.—Noth-
22 ing in this subsection shall be construed to pro-
23 hibit a plan, issuer, or provider from estab-
24 lishing and enforcing reasonable peer review or
25 utilization review protocols or determining

1 whether a protected health care professional has
2 complied with those protocols or from estab-
3 lishing and enforcing internal procedures for
4 the purpose of addressing quality concerns.

5 (C) RELATION TO OTHER RIGHTS.—Noth-
6 ing in this subsection shall be construed to
7 abridge rights of participants, beneficiaries, en-
8 rollees, and protected health care professionals
9 under other applicable Federal or State laws.

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

15 (A) with respect to a group health plan or
16 health insurance issuer, is an employee of the
17 plan or issuer or has a contract with the plan
18 or issuer for provision of services for which ben-
19 efits are available under the plan or issuer; or

20 (B) with respect to an institutional health
21 care provider, is an employee of the provider or
22 has a contract or other arrangement with the
23 provider respecting the provision of health care
24 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 713 of the Employee Retirement Income Security Act of 1974.

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

(1) ACTIVELY PRACTICING.—The term ''actively practicing'' means, with respect to a physician or other health care professional, such a physician or professional who provides professional services to individual patients on average at least two full days per week.

1 (2) APPLICABLE AUTHORITY.—The term ''ap-
2 plicable authority'' means—
3 (A) in the case of a group health plan, the
4 Secretary of Health and Human Services and
5 the Secretary of Labor; and
6 (B) in the case of a health insurance issuer
7 with respect to a specific provision of this title,
8 the applicable State authority (as defined in
9 section 2791(d) of the Public Health Service
10 Act), or the Secretary of Health and Human
11 Services, if such Secretary is enforcing such
12 provision under section 2722(a)(2) or
13 2761(a)(2) of the Public Health Service Act.
14 (3) CLINICAL PEER.—The term ''clinical peer''
15 means, with respect to a review or appeal, an ac-
16 tively practicing physician (allopathic or osteopathic)
17 or other actively practicing health care professional
18 who holds a nonrestricted license, and who is appro-
19 priately credentialed in the same or similar specialty
20 or subspecialty (as appropriate) as typically handles
21 the medical condition, procedure, or treatment under
22 review or appeal and includes a pediatric specialist
23 where appropriate; except that only a physician
24 (allopathic or osteopathic) may be a clinical peer

1 with respect to the review or appeal of treatment
2 recommended or rendered by a physician.
3 (4) ENROLLEE.—The term ''enrollee'' means,
4 with respect to health insurance coverage offered by
5 a health insurance issuer, an individual enrolled with
6 the issuer to receive such coverage.
7 (5) GROUP HEALTH PLAN.—The term ''group
8 health plan'' has the meaning given such term in
9 section 733(a) of the Employee Retirement Income
10 Security Act of 1974 and in section 2791(a)(1) of
11 the Public Health Service Act.
12 (6) HEALTH CARE PROFESSIONAL.—The term
13 ''health care professional'' means an individual who
14 is licensed, accredited, or certified under State law
15 to provide specified health care services and who is
16 operating within the scope of such licensure, accredi-
17 tation, or certification.
18 (7) HEALTH CARE PROVIDER.—The term
19 ''health care provider'' includes a physician or other
20 health care professional, as well as an institutional
21 or other facility or agency that provides health care
22 services and that is licensed, accredited, or certified
23 to provide health care items and services under ap-
24 plicable State law.

1 (8) NETWORK.—The term ''network'' means,
2 with respect to a group health plan or health insur-
3 ance issuer offering health insurance coverage, the
4 participating health care professionals and providers
5 through whom the plan or issuer provides health
6 care items and services to participants, beneficiaries,
7 or enrollees.

8 (9) NONPARTICIPATING.—The term ''non-
9 participating'' means, with respect to a health care
10 provider that provides health care items and services
11 to a participant, beneficiary, or enrollee under group
12 health plan or health insurance coverage, a health
13 care provider that is not a participating health care
14 provider with respect to such items and services.

15 (10) PARTICIPATING.—The term ''partici-
16 pating'' means, with respect to a health care pro-
17 vider that provides health care items and services to
18 a participant, beneficiary, or enrollee under group
19 health plan or health insurance coverage offered by
20 a health insurance issuer, a health care provider that
21 furnishes such items and services under a contract
22 or other arrangement with the plan or issuer.

23 (11) PRIOR AUTHORIZATION.—The term ''prior
24 authorization'' means the process of obtaining prior
25 approval from a health insurance issuer or group

1 health plan for the provision or coverage of medical
2 services.

3 **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**
4 **TION.**

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

7 (1) IN GENERAL.—Subject to paragraph (2),
8 this title shall not be construed to supersede any
9 provision of State law which establishes, implements,
10 or continues in effect any standard or requirement
11 solely relating to health insurance issuers (in connec-
12 tion with group health insurance coverage or other-
13 wise) except to the extent that such standard or re-
14 quirement prevents the application of a requirement
15 of this title.

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

22 (b) DEFINITIONS.—For purposes of this section:

23 (1) STATE LAW.—The term ''State law'' in-
24 cludes all laws, decisions, rules, regulations, or other
25 State action having the effect of law, of any State.

1 A law of the United States applicable only to the
2 District of Columbia shall be treated as a State law
3 rather than a law of the United States.

4 (2) STATE.—The term ''State'' includes a
5 State, the District of Columbia, Puerto Rico, the
6 Virgin Islands, Guam, American Samoa, the North-
7 ern Mariana Islands, any political subdivisions of
8 such, or any agency or instrumentality of such.

9 **SEC. 153. EXCLUSIONS.**

10 (a) NO BENEFIT REQUIREMENTS.—Nothing in this
11 title shall be construed to require a group health plan or
12 a health insurance issuer offering health insurance cov-
13 erage to include specific items and services (including
14 abortions) under the terms of such plan or coverage, other
15 than those provided under the terms of such plan or cov-
16 erage.

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

19 (1) IN GENERAL.—The provisions of sections
20 111 through 117 shall not apply to a group health
21 plan or health insurance coverage if the only cov-
22 erage offered under the plan or coverage is fee-for-
23 service coverage (as defined in paragraph (2)).

24 (2) FEE-FOR-SERVICE COVERAGE DEFINED.—
25 For purposes of this subsection, the term ''fee-for-

1 service coverage'' means coverage under a group
2 health plan or health insurance coverage that—
3 (A) reimburses hospitals, health profes-
4 sionals, and other providers on the basis of a
5 rate determined by the plan or issuer on a fee-
6 for-service basis without placing the provider at
7 financial risk;
8 (B) does not vary reimbursement for such
9 a provider based on an agreement to contract
10 terms and conditions or the utilization of health
11 care items or services relating to such provider;
12 (C) does not restrict the selection of pro-
13 viders among those who are lawfully authorized
14 to provide the covered services and agree to ac-
15 cept the terms and conditions of payment estab-
16 lished under the plan or by the issuer; and
17 (D) for which the plan or issuer does not
18 require prior authorization before providing cov-
19 erage for any services.

20 **SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.**

21 Only for purposes of applying the requirements of
22 this title under sections 2707 and 2753 of the Public
23 Health Service Act and section 714 of the Employee Re-
24 tirement Income Security Act of 1974, section
25 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee

Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor 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.

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.

"(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I

1 of the Bipartisan Consensus Managed Care Improvement
2 Act of 1999, and each health insurance issuer shall comply
3 with patient protection requirements under such title with
4 respect to group health insurance coverage it offers, and
5 such requirements shall be deemed to be incorporated into
6 this subsection.

7 ''(b) NOTICE.—A group health plan shall comply with
8 the notice requirement under section 711(d) of the Em-
9 ployee Retirement Income Security Act of 1974 with re-
10 spect to the requirements referred to in subsection (a) and
11 a health insurance issuer shall comply with such notice
12 requirement as if such section applied to such issuer and
13 such issuer were a group health plan.''.

14 (b) CONFORMING AMENDMENT.—Section
15 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))
16 is amended by inserting ''(other than section 2707)'' after
17 ''requirements of such subparts''.

18 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
19 **ANCE COVERAGE.**

20 Part B of title XXVII of the Public Health Service
21 Act is amended by inserting after section 2752 the fol-
22 lowing new section:

23 **''SEC. 2753. PATIENT PROTECTION STANDARDS.**

24 ''(a) IN GENERAL.—Each health insurance issuer
25 shall comply with patient protection requirements under

1 title I of the Bipartisan Consensus Managed Care Im-
2 provement Act of 1999 with respect to individual health
3 insurance coverage it offers, and such requirements shall
4 be deemed to be incorporated into this subsection.

5 ‘‘(b) NOTICE.—A health insurance issuer under this
6 part shall comply with the notice requirement under sec-
7 tion 711(d) of the Employee Retirement Income Security
8 Act of 1974 with respect to the requirements of such title
9 as if such section applied to such issuer and such issuer
10 were a group health plan.’’.

11 TITLE III—AMENDMENTS TO 12 THE EMPLOYEE RETIREMENT 13 INCOME SECURITY ACT OF 14 1974

15 SEC. 301. APPLICATION OF PATIENT PROTECTION STAND- 16 ARDS TO GROUP HEALTH PLANS AND GROUP 17 HEALTH INSURANCE COVERAGE UNDER THE 18 EMPLOYEE RETIREMENT INCOME SECURITY 19 ACT OF 1974.

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

23 ‘‘SEC. 714. PATIENT PROTECTION STANDARDS.

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

1 group health insurance coverage in connection with such
2 a plan) shall comply with the requirements of title I of
3 the Bipartisan Consensus Managed Care Improvement
4 Act of 1999 (as in effect as of the date of the enactment
5 of such Act), and such requirements shall be deemed to
6 be incorporated into this subsection.

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

9 "(1) SATISFACTION OF CERTAIN REQUIRE-
10 MENTS THROUGH INSURANCE.—For purposes of
11 subsection (a), insofar as a group health plan pro-
12 vides benefits in the form of health insurance cov-
13 erage through a health insurance issuer, the plan
14 shall be treated as meeting the following require-
15 ments of title I of the Bipartisan Consensus Man-
16 aged Care Improvement Act of 1999 with respect to
17 such benefits and not be considered as failing to
18 meet such requirements because of a failure of the
19 issuer to meet such requirements so long as the plan
20 sponsor or its representatives did not cause such
21 failure by the issuer:

22 "(A) Section 112 (relating to choice of pro-
23 viders).

24 "(B) Section 113 (relating to access to
25 emergency care).

1 "(C) Section 114 (relating to access to
2 specialty care).
3 "(D) Section 115 (relating to access to ob-
4 stetrical and gynecological care).
5 "(E) Section 116 (relating to access to pe-
6 diatric care).
7 "(F) Section 117(a)(1) (relating to con-
8 tinuity in case of termination of provider con-
9 tract) and section 117(a)(2) (relating to con-
10 tinuity in case of termination of issuer con-
11 tract), but only insofar as a replacement issuer
12 assumes the obligation for continuity of care.
13 "(G) Section 118 (relating to access to
14 needed prescription drugs).
15 "(H) Section 119 (relating to coverage for
16 individuals participating in approved clinical
17 trials.)
18 "(I) Section 134 (relating to payment of
19 claims).
20 "(2) INFORMATION.—With respect to informa-
21 tion required to be provided or made available under
22 section 121, in the case of a group health plan that
23 provides benefits in the form of health insurance
24 coverage through a health insurance issuer, the Sec-
25 retary shall determine the circumstances under

1 which the plan is not required to provide or make
2 available the information (and is not liable for the
3 issuer's failure to provide or make available the in-
4 formation), if the issuer is obligated to provide and
5 make available (or provides and makes available)
6 such information.

7 "(3) GRIEVANCE AND INTERNAL APPEALS.—
8 With respect to the internal appeals process and the
9 grievance system required to be established under
10 sections 102 and 104, in the case of a group health
11 plan that provides benefits in the form of health in-
12 surance coverage through a health insurance issuer,
13 the Secretary shall determine the circumstances
14 under which the plan is not required to provide for
15 such process and system (and is not liable for the
16 issuer's failure to provide for such process and sys-
17 tem), if the issuer is obligated to provide for (and
18 provides for) such process and system.

19 "(4) EXTERNAL APPEALS.—Pursuant to rules
20 of the Secretary, insofar as a group health plan en-
21 ters into a contract with a qualified external appeal
22 entity for the conduct of external appeal activities in
23 accordance with section 103, the plan shall be treat-
24 ed as meeting the requirement of such section and

1 is not liable for the entity's failure to meet any re-
2 quirements under such section.
3 "(5) APPLICATION TO PROHIBITIONS.—Pursu-
4 ant to rules of the Secretary, if a health insurance
5 issuer offers health insurance coverage in connection
6 with a group health plan and takes an action in vio-
7 lation of any of the following sections, the group
8 health plan shall not be liable for such violation un-
9 less the plan caused such violation:
10 "(A) Section 131 (relating to prohibition of
11 interference with certain medical communica-
12 tions).
13 "(B) Section 132 (relating to prohibition
14 of discrimination against providers based on li-
15 censure).
16 "(C) Section 133 (relating to prohibition
17 against improper incentive arrangements).
18 "(D) Section 135 (relating to protection
19 for patient advocacy).
20 "(6) CONSTRUCTION.—Nothing in this sub-
21 section shall be construed to affect or modify the re-
22 sponsibilities of the fiduciaries of a group health
23 plan under part 4 of subtitle B.
24 "(7) APPLICATION TO CERTAIN PROHIBITIONS
25 AGAINST RETALIATION.—With respect to compliance

with the requirements of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999, 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 Consensus Managed Care Improvement Act of 1999 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 may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(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 Consensus Managed Care Improvement Act of 1999 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. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

1 "(e) PREEMPTION NOT TO APPLY TO CERTAIN AC-
2 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-
3 FITS.—
4 "(1) NON-PREEMPTION OF CERTAIN CAUSES OF
5 ACTION.—
6 "(A) IN GENERAL.—Except as provided in
7 this subsection, nothing in this title shall be
8 construed to invalidate, impair, or supersede
9 any cause of action by a participant or bene-
10 ficiary (or the estate of a participant or bene-
11 ficiary) under State law to recover damages re-
12 sulting from personal injury or for wrongful
13 death against any person—
14 "(i) in connection with the provision
15 of insurance, administrative services, or
16 medical services by such person to or for
17 a group health plan as defined in section
18 733), or
19 "(ii) that arises out of the arrange-
20 ment by such person for the provision of
21 such insurance, administrative services, or
22 medical services by other persons.
23 "(B) LIMITATION ON PUNITIVE DAM-
24 AGES.—The plan or issuer is not liable for any
25 punitive, exemplary, or similar damages in the

1 case of a cause of action brought under sub-
2 paragraph (A) if—
3 "(i) it relates to an externally appeal-
4 able decision (as defined in subsection
5 (a)(2) of section 103 of the Bipartisan
6 Consensus Managed Care Improvement
7 Act of 1999);
8 "(ii) an external appeal with respect
9 to such decision was completed under such
10 section 103;
11 "(iii) in the case such external appeal
12 was initiated by the plan or issuer filing
13 the request for the external appeal, the re-
14 quest was filed on a timely basis before the
15 date the action was brought or, if later,
16 within 30 days after the date the exter-
17 nally appealable decision was made; and
18 "(iv) the plan or issuer complied with
19 the determination of the external appeal
20 entity upon receipt of the determination of
21 the external appeal entity.
22 The provisions of this subparagraph supersede
23 any State law or common law to the contrary.
24 "(C) PERSONAL INJURY DEFINED.—For
25 purposes of this subsection, the term 'personal

1 injury' means a physical injury and includes an
2 injury arising out of the treatment (or failure
3 to treat) a mental illness or disease.
4 "(2) EXCEPTION FOR EMPLOYERS AND OTHER
5 PLAN SPONSORS.—
6 "(A) IN GENERAL.—Subject to subpara-
7 graph (B), paragraph (1) does not authorize—
8 "(i) any cause of action against an
9 employer or other plan sponsor maintain-
10 ing the group health plan (or against an
11 employee of such an employer or sponsor
12 acting within the scope of employment), or
13 "(ii) a right of recovery or indemnity
14 by a person against an employer or other
15 plan sponsor (or such an employee) for
16 damages assessed against the person pur-
17 suant to a cause of action under paragraph
18 (1).
19 "(B) SPECIAL RULE.—Subparagraph (A)
20 shall not preclude any cause of action described
21 in paragraph (1) against an employer or other
22 plan sponsor (or against an employee of such
23 an employer or sponsor acting within the scope
24 of employment) if—

1 ''(i) such action is based on the em-
2 ployer's or other plan sponsor's (or em-
3 ployee's) exercise of discretionary authority
4 to make a decision on a claim for benefits
5 covered under the plan or health insurance
6 coverage in the case at issue; and
7 ''(ii) the exercise by such employer or
8 other plan sponsor (or employee) of such
9 authority resulted in personal injury or
10 wrongful death.
11 ''(C) EXCEPTION.—The exercise of discre-
12 tionary authority described in subparagraph
13 (B)(i) shall not be construed to include—
14 ''(i) the decision to include or exclude
15 from the plan any specific benefit;
16 ''(ii) any decision to provide extra-con-
17 tractual benefits; or
18 ''(iii) any decision not to consider the
19 provision of a benefit while internal or ex-
20 ternal review is being conducted.
21 ''(3) FUTILITY OF EXHAUSTION.—An individual
22 bringing an action under this subsection is not re-
23 quired to exhaust administrative processes under
24 section 102 or 103 of the Bipartisan Consensus
25 Managed Care Improvement Act of 1999 where the

1 injury to or death of such individual has occurred
2 before the completion of such processes.''.
3 ''(4) CONSTRUCTION.—Nothing in this sub-
4 section shall be construed as—
5 ''(A) permitting a cause of action under
6 State law for the failure to provide an item or
7 service which is specifically excluded under the
8 group health plan involved; or
9 ''(B) as preempting a State law which re-
10 quires an affidavit or certificate of merit in a
11 civil action.''.
12 (b) EFFECTIVE DATE.—The amendment made by
13 subsection (a) shall apply to acts and omissions occurring
14 on or after the date of the enactment of this Act from
15 which a cause of action arises.

16 TITLE IV—APPLICATION TO 17 GROUP HEALTH PLANS 18 UNDER THE INTERNAL REV- 19 ENUE CODE OF 1986

20 **SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE**
21 **OF 1986.**

22 Subchapter B of chapter 100 of the Internal Revenue
23 Code of 1986 is amended—

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

"Sec. 9813. Standard relating to patient freedom of choice.";

4 and
5 (2) by inserting after section 9812 the fol-
6 lowing:

7 **"SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF**
8 **RIGHTS.**

9 "A group health plan shall comply with the require-
10 ments of title I of the Bipartisan Consensus Managed
11 Care Improvement Act of 1999 (as in effect as of the date
12 of the enactment of such Act), and such requirements
13 shall be deemed to be incorporated into this section.".

14 TITLE V—EFFECTIVE DATES; CO-
15 ORDINATION IN IMPLEMEN-
16 TATION

17 **SEC. 501. EFFECTIVE DATES.**

18 (a) GROUP HEALTH COVERAGE.—
19 (1) IN GENERAL.—Subject to paragraph (2),
20 the amendments made by sections 201(a), 301, and
21 401 (and title I insofar as it relates to such sections)
22 shall apply with respect to group health plans, and
23 health insurance coverage offered in connection with
24 group health plans, for plan years beginning on or
25 after January 1, 2000 (in this section referred to as

1 the ''general effective date'') and also shall apply to
2 portions of plan years occurring on and after such
3 date.

4 (2) TREATMENT OF COLLECTIVE BARGAINING
5 AGREEMENTS.—In the case of a group health plan
6 maintained pursuant to 1 or more collective bar-
7 gaining agreements between employee representa-
8 tives and 1 or more employers ratified before the
9 date of enactment of this Act, the amendments made
10 by sections 201(a), 301, and 401 (and title I insofar
11 as it relates to such sections) shall not apply to plan
12 years beginning before the later of—

13 (A) the date on which the last collective
14 bargaining agreements relating to the plan ter-
15 minates (determined without regard to any ex-
16 tension thereof agreed to after the date of en-
17 actment of this Act), or

18 (B) the general effective date.

19 For purposes of subparagraph (A), any plan amend-
20 ment made pursuant to a collective bargaining
21 agreement relating to the plan which amends the
22 plan solely to conform to any requirement added by
23 this Act shall not be treated as a termination of
24 such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—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.

SEC. 502. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury 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.

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

1 (1) ESTABLISHMENT.—There is established a
2 panel to be known as the Health Care Panel to De-
3 vise a Uniform Explanation of Benefits (in this sec-
4 tion referred to as the ''Panel'').
5 (2) DUTIES OF PANEL.—
6 (A) IN GENERAL.—The Panel shall devise
7 a single form for use by third-party health care
8 payers for the remittance of claims to providers.
9 (B) DEFINITION.—For purposes of this
10 section, the term ''third-party health care
11 payer'' means any entity that contractually
12 pays health care bills for an individual.
13 (3) MEMBERSHIP.—
14 (A) SIZE AND COMPOSITION.—The Sec-
15 retary of Health and Human Services shall de-
16 termine the number of members and the com-
17 position of the Panel. Such Panel shall include
18 equal numbers of representatives of private in-
19 surance organizations, consumer groups, State
20 insurance commissioners, State medical soci-
21 eties, State hospital associations, and State
22 medical specialty societies.
23 (B) TERMS OF APPOINTMENT.—The mem-
24 bers of the Panel shall serve for the life of the
25 Panel.

1 (C) VACANCIES.—A vacancy in the Panel
2 shall not affect the power of the remaining
3 members to execute the duties of the Panel, but
4 any such vacancy shall be filled in the same
5 manner in which the original appointment was
6 made.
7 (4) PROCEDURES.—
8 (A) MEETINGS.—The Panel shall meet at
9 the call of a majority of its members.
10 (B) FIRST MEETING.—The Panel shall
11 convene not later than 60 days after the date
12 of the enactment of the Bipartisan Consensus
13 Managed Care Improvement Act of 1999.
14 (C) QUORUM.—A quorum shall consist of
15 a majority of the members of the Panel.
16 (D) HEARINGS.—For the purpose of car-
17 rying out its duties, the Panel may hold such
18 hearings and undertake such other activities as
19 the Panel determines to be necessary to carry
20 out its duties.
21 (5) ADMINISTRATION.—
22 (A) COMPENSATION.—Except as provided
23 in subparagraph (B), members of the Panel
24 shall receive no additional pay, allowances, or
25 benefits by reason of their service on the Panel.

1 (B) TRAVEL EXPENSES AND PER DIEM.—
2 Each member of the Panel who is not an officer
3 or employee of the Federal Government shall
4 receive travel expenses and per diem in lieu of
5 subsistence in accordance with sections 5702
6 and 5703 of title 5, United States Code.
7 (C) CONTRACT AUTHORITY.—The Panel
8 may contract with and compensate government
9 and private agencies or persons for items and
10 services, without regard to section 3709 of the
11 Revised Statutes (41 U.S.C. 5).
12 (D) USE OF MAILS.—The Panel may use
13 the United States mails in the same manner
14 and under the same conditions as Federal agen-
15 cies and shall, for purposes of the frank, be
16 considered a commission of Congress as de-
17 scribed in section 3215 of title 39, United
18 States Code.
19 (E) ADMINISTRATIVE SUPPORT SERV-
20 ICES.—Upon the request of the Panel, the Sec-
21 retary of Health and Human Services shall pro-
22 vide to the Panel on a reimbursable basis such
23 administrative support services as the Panel
24 may request.

1 (6) SUBMISSION OF FORM.—Not later than 2
2 years after the first meeting, the Panel shall submit
3 a form to the Secretary of Health and Human Serv-
4 ices for use by third-party health care payers.
5 (7) TERMINATION.—The Panel shall terminate
6 on the day after submitting the form under para-
7 graph (6).
8 (b) REQUIREMENT FOR USE OF FORM BY THIRD-
9 PARTY CARE PAYERS.—A third-party health care payer
10 shall be required to use the form devised under subsection
11 (a) for plan years beginning on or after 5 years following
12 the date of the enactment of this Act.

○