

106TH CONGRESS
2D SESSION

H. R. 5628

To amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide for a patients' bill of rights, patient access to information, and accountability of health plans, and to expand access to health care coverage through tax incentives.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 3, 2000

Mr. SHADEGG (for himself, Mr. COBURN, Mr. SALMON, and Mr. ADERHOLT) 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

A BILL

To amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide for a patients' bill of rights, patient access to information, and accountability of health plans, and to expand access to health care coverage through tax incentives.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Common Sense Patients’ Bill of Rights Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—PATIENTS’ BILL OF RIGHTS

Subtitle A—Right to Advice and Care

Sec. 101. Patient right to medical advice and care under ERISA.

“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 721. Access to emergency care.

“Sec. 722. Offering of choice of coverage options.

“Sec. 723. Patient access to obstetric and gynecological care.

“Sec. 724. Access to pediatric care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

“Sec. 727. Prohibition of interference with certain medical communica-
tions.

“Sec. 728. Patient’s right to prescription drugs.

“Sec. 729. Self-payment for behavioral health care services.

“Sec. 730. Coverage for individuals participating in approved cancer clin-
ical trials.

“Sec. 730A. Prohibition of discrimination against providers based on licen-
sure.

“Sec. 730B. Prohibition against improper incentive arrangements.

“Sec. 730C. Payment of clean claims.

“Sec. 730D. Generally applicable provision.

“Sec. 730E. Exclusion from access to managed care provisions for fee-for-
service coverage.

“Sec. 730F. Additional definitions.

Sec. 102. Conforming amendments to the Public Health Service Act.

Sec. 103. Conforming amendments to the Internal Revenue Code of 1986.

Subtitle B—Right to Information About Plans and Providers

Sec. 111. Information about plans and coverage under ERISA.

“Sec. 714. Patient access to information.

Sec. 112. Conforming amendments to Public Health Service Act.

Sec. 113. Conforming amendments to the Internal Revenue Code of 1986.

Subtitle C—Right to Hold Health Plans Accountable

Sec. 121. Amendments to Employee Retirement Income Security Act of 1974.

“Sec. 503A. Utilization review activities.

“Sec. 503B. Procedures for initial claims for benefits and prior authoriza-
tion determinations.

“Sec. 503C. Internal appeals of claims denials.

“Sec. 503D. Independent external appeals procedures.

Sec. 122. Conforming amendments to Public Health Service Act.

Sec. 123. Conforming amendments to the Internal Revenue Code of 1986.

Subtitle D—State Flexibility in Applying Requirements to Health Insurance Issuers

Sec. 141. State flexibility in applying requirements to health insurance issuers under ERISA; plan satisfaction of certain requirements.

Sec. 142. State flexibility in applying requirements to health insurance issuers under the Public Health Service Act.

Subtitle E—Effective Dates; Coordination in Implementation; Miscellaneous Provisions

Sec. 151. Effective dates.

Sec. 152. Regulations; coordination.

Sec. 153. No benefit requirements.

Sec. 154. Severability.

TITLE II—REMEDIES

Sec. 201. Availability of court remedies.

Sec. 202. Severability.

TITLE III—HEALTH CARE COVERAGE ACCESS TAX INCENTIVES

Sec. 301. Expanded availability of medical savings accounts.

Sec. 302. Deduction for 100 percent of health insurance costs of self-employed individuals.

TITLE IV—HEALTH CARE PAPERWORK

Sec. 401. Health care paperwork simplification.

1 **TITLE I—PATIENTS’ BILL OF**
2 **RIGHTS**
3 **Subtitle A—Right to Advice and**
4 **Care**

5 **SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE**
6 **UNDER ERISA.**

7 (a) IN GENERAL.—Part 7 of subtitle B of title I of
8 the Employee Retirement Income Security Act of 1974
9 (29 U.S.C. 1181 et seq.) is amended—

1 (1) by redesignating subpart C as subpart D;

2 and

3 (2) by inserting after subpart B the following:

4 **“Subpart C—Patient Right to Medical Advice and**
5 **Care**

6 **“SEC. 721. ACCESS TO EMERGENCY CARE.**

7 “(a) COVERAGE OF EMERGENCY SERVICES.—

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

15 “(A) without the need for any prior au-
16 thorization determination;

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

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

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

1 “(ii) by a participating health care
2 provider without prior authorization,
3 the participant or beneficiary is not liable for
4 amounts that exceed the amounts of liability
5 that would be incurred if the services were pro-
6 vided by a participating health care provider
7 with prior authorization; and

8 “(D) without regard to any other term or
9 condition of such coverage (other than exclusion
10 or coordination of benefits, or an affiliation or
11 waiting period, permitted under section 2701 of
12 the Public Health Service Act, section 701, or
13 section 9801 of the Internal Revenue Code of
14 1986, and other than applicable cost-sharing).

15 “(2) DEFINITIONS.—In this section:

16 “(A) EMERGENCY MEDICAL CONDITION.—
17 The term ‘emergency medical condition’ means
18 a medical condition manifesting itself by acute
19 symptoms of sufficient severity (including se-
20 vere pain) such that a prudent layperson, who
21 possesses an average knowledge of health and
22 medicine, could reasonably expect the absence
23 of immediate medical attention to result in a
24 condition described in clause (i), (ii), or (iii) of

1 section 1867(e)(1)(A) of the Social Security Act
2 (42 U.S.C. 1395dd(e)(1)(A)).

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

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

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

19 “(C) STABILIZE.—The term ‘to stabilize’
20 means, with respect to an emergency medical
21 condition, to provide such medical treatment of
22 the condition as may be necessary to assure,
23 within reasonable medical probability, that no
24 material deterioration of the condition is likely

1 to result from or occur during the transfer of
2 the individual from a facility.

3 “(b) REIMBURSEMENT FOR MAINTENANCE CARE
4 AND POST-STABILIZATION CARE.—If benefits are avail-
5 able under a group health plan, or under health insurance
6 coverage offered by a health insurance issuer in connection
7 with such a plan, with respect to maintenance care or
8 post-stabilization care covered under the guidelines estab-
9 lished under section 1852(d)(2) of the Social Security Act,
10 the plan or issuer shall provide for reimbursement with
11 respect to such services provided to a participant or bene-
12 ficiary other than through a participating health care pro-
13 vider in a manner consistent with subsection (a)(1)(C)
14 (and shall otherwise comply with such guidelines).

15 “(c) COVERAGE OF EMERGENCY AMBULANCE SERV-
16 ICES.—

17 “(1) IN GENERAL.—If a group health plan, or
18 health insurance coverage provided by a health in-
19 surance issuer in connection with such a plan, pro-
20 vides any benefits with respect to ambulance services
21 and emergency services, the plan or issuer shall
22 cover emergency ambulance services (as defined in
23 paragraph (2)) furnished under the plan or coverage
24 under the same terms and conditions under subpara-

1 graphs (A) through (D) of subsection (a)(1) under
2 which coverage is provided for emergency services.

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

20 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
21 tion shall be construed to prohibit a group health plan or
22 a health insurance issuer from negotiating reimbursement
23 rates with a nonparticipating provider for items or services
24 provided under this section.

1 **“SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

2 “(a) REQUIREMENT.—If a group health plan provides
3 coverage for benefits only through a defined set of partici-
4 pating health care professionals, the plan shall offer each
5 participant the option to purchase point-of-service cov-
6 erage (as defined in subsection (b)) for all such benefits
7 for which coverage is otherwise so limited. Such option
8 shall be made available to the participant at the time of
9 enrollment under the plan and at such other times as the
10 plan offers the participant a choice of coverage options.

11 “(b) POINT-OF-SERVICE COVERAGE DEFINED.—In
12 this section, the term ‘point-of-service coverage’ means,
13 with respect to benefits covered under a group health plan,
14 coverage of such benefits when provided by a nonpartici-
15 pating health care professional.

16 “(c) SMALL EMPLOYER EXEMPTION.—

17 “(1) IN GENERAL.—The requirement of sub-
18 section (a) shall not apply to a group health plan
19 with respect to a small employer if the employer
20 demonstrates that compliance with such requirement
21 would result in an increase in overall costs to the
22 employer.

23 “(2) SMALL EMPLOYER DEFINED.—For pur-
24 poses of subparagraph (A), the term ‘small em-
25 ployer’ means, in connection with a group health
26 plan with respect to a calendar year and a plan year,

1 an employer who employed an average of fewer than
2 25 employees on days during the preceding calendar
3 year and fewer than 25 employees on the first day
4 of the plan year.

5 “(3) DETERMINATION OF EMPLOYER SIZE.—
6 For purposes of this subsection, the provisions of
7 subparagraph (C) of section 712(e)(1) shall apply in
8 determining employer size.

9 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
10 tion shall be construed—

11 “(1) as requiring coverage for benefits for a
12 particular type of health care professional;

13 “(2) as requiring an increase in the level of em-
14 ployer contributions or as permitting an employer to
15 comply with the requirements of this section by
16 means of reducing the level of employer contribu-
17 tions attributable to coverage with respect to any
18 participant or group of participants in relation to
19 the level that would otherwise be maintained if such
20 requirements did not apply;

21 “(3) as preventing a group health plan from
22 imposing, on a participant who exercises the point-
23 of-service coverage option under subsection (a), the
24 additional cost of creation and maintenance of the
25 option as well as any additional other costs (includ-

1 ing additional cost-sharing) attributable to the op-
2 tion; or

3 “(4) to require that a group health plan include
4 coverage of health care professionals that the plan
5 excludes because of fraud, quality of care, or other
6 similar reasons with respect to such professionals.

7 **“SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
8 **LOGICAL CARE.**

9 “(a) GENERAL RIGHTS.—

10 “(1) DIRECT ACCESS.—A group health plan, or
11 health insurance coverage offered by a health insur-
12 ance issuer in connection with such a plan, described
13 in subsection (b) may not require authorization or
14 referral by the plan, issuer, or any other person, in-
15 cluding the primary care provider described in sub-
16 section (b)(2), in the case of a female participant or
17 beneficiary who seeks coverage for obstetric or gyne-
18 cological care provided by a participating physician
19 who specializes in obstetrics or gynecology.

20 “(2) OBSTETRIC AND GYNECOLOGICAL CARE.—

21 Such a plan or issuer shall treat the provision of ob-
22 stetric and gynecological care, and the ordering of
23 related obstetric and gynecological items and serv-
24 ices, pursuant to the direct access described under
25 paragraph (1), by a participating physician who spe-

1 specializes in obstetrics or gynecology as the authoriza-
2 tion of the primary care provider.

3 “(b) APPLICATION OF SECTION.—A group health
4 plan, or health insurance coverage offered by a health in-
5 surance issuer in connection with such a plan, described
6 in this subsection is a plan or coverage that—

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

9 “(2) requires the designation by a participant
10 or beneficiary of a participating primary care pro-
11 vider other than a physician who specializes in ob-
12 stetrics or gynecology.

13 “(c) RULES OF CONSTRUCTION.—Nothing in this
14 section shall be construed—

15 “(1) to require that a group health plan or
16 health insurance issuer approve or provide coverage
17 for—

18 “(A) any items or services that are not
19 covered under the terms and conditions of the
20 group health plan or the health insurance cov-
21 erage;

22 “(B) any items or services that are not
23 medically necessary and appropriate; or

24 “(C) any items or services that are pro-
25 vided, ordered, or otherwise authorized under

1 subsection (a)(2) by a physician unless such
2 items or services are related to obstetric or
3 gynecologic care; or

4 “(2) to preclude a group health plan or a health
5 insurance issuer from requiring that the physician
6 described in subsection (a) notify the designated pri-
7 mary care professional or case manager of treatment
8 decisions in accordance with a process implemented
9 by the plan or issuer, except that the plan or issuer
10 shall not impose such a notification requirement on
11 the participant or beneficiary involved in the treat-
12 ment decision.

13 **“SEC. 724. ACCESS TO PEDIATRIC CARE.**

14 “If a group health plan, or health insurance coverage
15 offered by a health insurance issuer in connection with
16 such a plan, requires or provides for a participant or bene-
17 ficiary to designate a participating primary care provider
18 for a child of such participant or beneficiary, the plan or
19 issuer shall permit the participant or beneficiary to des-
20 ignate a physician who specializes in pediatrics as the
21 child’s primary care provider if such provider participates
22 in the network of the plan or issuer.

23 **“SEC. 725. TIMELY ACCESS TO SPECIALISTS.**

24 “(a) TIMELY ACCESS.—

1 “(1) IN GENERAL.—A group health plan, and a
2 health insurance issuer that offers health insurance
3 coverage in connection with such a plan, shall ensure
4 that participants and beneficiaries receive timely
5 coverage for access to specialists who are appro-
6 priate to the medical condition of the participant or
7 beneficiary, when such specialty care is a covered
8 benefit under the plan or coverage.

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

11 “(A) to require the coverage under a group
12 health plan or health insurance coverage of ben-
13 efits or services;

14 “(B) to prohibit a plan or issuer from in-
15 cluding providers in the network only to the ex-
16 tent necessary to meet the needs of the plan’s
17 participants and beneficiaries; or

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

20 “(3) ACCESS TO CERTAIN PROVIDERS.—

21 “(A) PARTICIPATING PROVIDERS.—Noth-
22 ing in this section shall be construed to prohibit
23 a group health plan or health insurance issuer
24 from requiring that a participant or beneficiary

1 obtain specialty care from a participating spe-
2 cialist.

3 “(B) NONPARTICIPATING PROVIDERS.—

4 “(i) IN GENERAL.—With respect to
5 specialty care under this section, if a group
6 health plan or health insurance issuer de-
7 termines that a participating specialist is
8 not available to provide such care to the
9 participant or beneficiary, the plan or
10 issuer shall provide for coverage of such
11 care by a nonparticipating specialist.

12 “(ii) TREATMENT OF NONPARTICI-
13 PATING PROVIDERS.—If a group health
14 plan or health insurance issuer refers a
15 participant or beneficiary to a nonpartici-
16 pating specialist pursuant to clause (i),
17 such specialty care shall be provided at no
18 additional cost to the participant or bene-
19 ficiary beyond what the participant or ben-
20 eficiary would otherwise pay for such spe-
21 cialty care if provided by a participating
22 specialist.

23 “(b) REFERRALS.—

24 “(1) AUTHORIZATION.—Nothing in this section
25 shall be construed to prohibit a group health plan or

1 health insurance issuer from requiring an authoriza-
2 tion in order to obtain coverage for specialty services
3 so long as such authorization is for an appropriate
4 duration or number of referrals.

5 “(2) SPECIALISTS AS GATEKEEPER FOR TREAT-
6 MENT OF ONGOING SPECIAL CONDITIONS.—

7 “(A) IN GENERAL.—A group health plan,
8 or a health insurance issuer in connection with
9 the provision of group health insurance cov-
10 erage, shall have a procedure by which an indi-
11 vidual who is a participant or beneficiary and
12 who has an ongoing special condition (as de-
13 fined in subparagraph (C)) may request and re-
14 ceive a referral to a specialist for such condition
15 who shall be responsible for and capable of pro-
16 viding and coordinating the individual’s care
17 with respect to the condition. Under such proce-
18 dures if such an individual’s care would most
19 appropriately be coordinated by such a spe-
20 cialist, such plan or issuer shall refer the indi-
21 vidual to such specialist.

22 “(B) TREATMENT FOR RELATED REFER-
23 RALS.—Such specialists shall be permitted to
24 treat the individual without a referral from the
25 individual’s primary care provider and may au-

1 thorize such referrals, procedures, tests, and
2 other medical services as the individual’s pri-
3 mary care provider would otherwise be per-
4 mitted to provide or authorize, subject to the
5 terms of the treatment (referred to in sub-
6 section (a)(3)(A)) with respect to the ongoing
7 special condition.

8 “(C) ONGOING SPECIAL CONDITION DE-
9 FINED.—In this paragraph, the term ‘ongoing
10 special condition’ means a condition or disease
11 that—

12 “(i) is life-threatening, degenerative,
13 congenital, or disabling, and

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

16 “(D) TERMS OF REFERRAL.—The provi-
17 sions of paragraphs (3) through (5) of sub-
18 section (a) apply with respect to referrals under
19 subparagraph (A) in the same manner as they
20 apply to referrals under subsection (a)(1).

21 “(E) CONSTRUCTION.—Nothing in this
22 paragraph shall be construed as preventing an
23 individual who is a participant or beneficiary
24 and who has an ongoing special condition from
25 having the individual’s primary care physician

1 assume the responsibilities for providing and co-
2 ordinating care described in subparagraph (A).

3 “(c) TREATMENT PLANS.—

4 “(1) IN GENERAL.—Nothing in this section
5 shall be construed to prohibit a group health plan or
6 health insurance issuer from requiring that specialty
7 care be provided pursuant to a treatment plan so
8 long as the treatment plan is—

9 “(A) developed by the specialist, in con-
10 sultation with the case manager or primary
11 care provider, and the participant or bene-
12 ficiary;

13 “(B) approved by the plan or issuer in a
14 timely manner if the plan requires such ap-
15 proval; and

16 “(C) in accordance with the applicable
17 quality assurance and utilization review stand-
18 ards of the plan or issuer.

19 “(2) NOTIFICATION.—Nothing in paragraph (1)
20 shall be construed as prohibiting a plan or issuer
21 from requiring the specialist to provide the plan or
22 issuer with regular updates on the specialty care
23 provided, as well as all other necessary medical in-
24 formation.

1 “(d) SPECIALIST DEFINED.—For purposes of this
2 section, the term ‘specialist’ means, with respect to the
3 medical condition of the participant or beneficiary, a
4 health care professional, facility, or center that has ade-
5 quate expertise (including age-appropriate expertise)
6 through appropriate training and experience or a physi-
7 cian pathologist who has adequate expertise through ap-
8 propriate training and experience.

9 **“SEC. 726. CONTINUITY OF CARE.**

10 “(a) TERMINATION OF PROVIDER.—If a contract be-
11 tween a group health plan, or health insurance issuer that
12 offers health insurance coverage in connection with such
13 a plan, and a treating health care provider is terminated
14 (as defined in paragraph (e)(4)), or benefits or coverage
15 provided by a health care provider are terminated because
16 of a change in the terms of provider participation in such
17 plan or coverage, and an individual who is a participant
18 or beneficiary in the plan is undergoing an active course
19 of treatment for a serious and complex condition, institu-
20 tional care, pregnancy, or terminal illness from the pro-
21 vider at the time the plan or issuer receives or provides
22 notice of such termination, the plan or issuer shall—

23 “(1) notify the individual, or arrange to have
24 the individual notified pursuant to subsection (d)(2),
25 on a timely basis of such termination;

1 “(2) provide the individual with an opportunity
2 to notify the plan or issuer of the individual’s need
3 for transitional care; and

4 “(3) subject to subsection (c), permit the indi-
5 vidual to elect to continue to be covered with respect
6 to the active course of treatment with the provider’s
7 consent during a transitional period (as provided for
8 under subsection (b)).

9 “(b) TRANSITIONAL PERIOD.—

10 “(1) SERIOUS AND COMPLEX CONDITIONS.—

11 The transitional period under this section with re-
12 spect to a serious and complex condition shall extend
13 for up to 90 days from the date of the notice de-
14 scribed in subsection (a)(1) of the provider’s termi-
15 nation.

16 “(2) INSTITUTIONAL OR INPATIENT CARE.—

17 “(A) IN GENERAL.—The transitional pe-
18 riod under this section for institutional or non-
19 elective inpatient care from a provider shall ex-
20 tend until the earlier of—

21 “(i) the expiration of the 90-day pe-
22 riod beginning on the date on which the
23 notice described in subsection (a)(1) of the
24 provider’s termination is provided; or

1 “(ii) the date of discharge of the indi-
2 vidual from such care or the termination of
3 the period of institutionalization.

4 “(B) SCHEDULED CARE.—The 90 day lim-
5 itation described in subparagraph (A)(i) shall
6 include post-surgical follow-up care relating to
7 non-elective surgery that has been scheduled be-
8 fore the date of the notice of the termination of
9 the provider under subsection (a)(1).

10 “(3) PREGNANCY.—If—

11 “(A) a participant or beneficiary was de-
12 termined to be pregnant at the time of a pro-
13 vider’s termination of participation, and

14 “(B) the provider was treating the preg-
15 nancy before date of the termination,
16 the transitional period under this subsection with re-
17 spect to provider’s treatment of the pregnancy shall
18 extend through the provision of post-partum care di-
19 rectly related to the delivery.

20 “(4) TERMINAL ILLNESS.—If—

21 “(A) a participant or beneficiary was de-
22 termined to be terminally ill (as determined
23 under section 1861(dd)(3)(A) of the Social Se-
24 curity Act) at the time of a provider’s termi-
25 nation of participation; and

1 “(B) the provider was treating the ter-
2 minal illness before the date of termination;
3 the transitional period under this subsection shall
4 extend for the remainder of the individual’s life for
5 care that is directly related to the treatment of the
6 terminal illness.

7 “(c) PERMISSIBLE TERMS AND CONDITIONS.—A
8 group health plan, and a health insurance issuer that of-
9 fers health insurance coverage in connection with such a
10 plan, may condition coverage of continued treatment by
11 a provider under this section upon the provider agreeing
12 to the following terms and conditions:

13 “(1) The treating health care provider agrees to
14 accept reimbursement from the plan or issuer and
15 individual involved (with respect to cost-sharing) at
16 the rates applicable prior to the start of the transi-
17 tional period as payment in full (or at the rates ap-
18 plicable under the replacement plan or coverage
19 after the date of the termination of the contract with
20 the group health plan or health insurance issuer)
21 and not to impose cost-sharing with respect to the
22 individual in an amount that would exceed the cost-
23 sharing that could have been imposed if the contract
24 referred to in this section had not been terminated.

1 “(2) The treating health care provider agrees to
2 adhere to the quality assurance standards of the
3 plan or issuer responsible for payment under para-
4 graph (1) (to the extent such quality assurance
5 standards meet the professionally accepted stand-
6 ards of care) and to provide to such plan or issuer
7 necessary medical information related to the care
8 provided.

9 “(3) The treating health care provider agrees
10 otherwise to adhere to such plan’s or issuer’s policies
11 and procedures (to the extent such policies and pro-
12 cedures meet the professionally accepted standards
13 of care), including procedures regarding referrals
14 and obtaining prior authorization and providing
15 services pursuant to a treatment plan (if any) ap-
16 proved by the plan or issuer.

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

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

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

1 “(A) notify participants or beneficiaries of
2 their rights under this section; or

3 “(B) provide the plan or issuer with the
4 name of each participant or beneficiary who the
5 provider believes is eligible for transitional care
6 under this section.

7 “(e) DEFINITIONS.—In this section:

8 “(1) CONTRACT.—The term ‘contract between a
9 plan or issuer and a treating health care provider’
10 shall include a contract between such a plan or
11 issuer and an organized network of providers.

12 “(2) HEALTH CARE PROVIDER.—The term
13 ‘health care provider’ or ‘provider’ means—

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

19 “(B) any entity that is engaged in the de-
20 livery of health care services in a State and
21 that, if it is required by State law or regulation
22 to be licensed or certified by the State to en-
23 gage in the delivery of such services in the
24 State, is so licensed.

1 “(3) SERIOUS AND COMPLEX CONDITION.—The
2 term ‘serious and complex condition’ means, with re-
3 spect to a participant or beneficiary under the plan
4 or coverage, a condition that is medically deter-
5 minable and—

6 “(A) in the case of an acute illness, is a
7 condition serious enough to require specialized
8 medical treatment to avoid the reasonable possi-
9 bility of death or permanent harm; or

10 “(B) in the case of a chronic illness or con-
11 dition, is an illness or condition that—

12 “(i) is complex and difficult to man-
13 age;

14 “(ii) is disabling or life-threatening;
15 and

16 “(iii) requires—

17 “(I) frequent monitoring over a
18 prolonged period of time and requires
19 substantial on-going specialized med-
20 ical care; or

21 “(II) frequent ongoing specialized
22 medical care across a variety of do-
23 mains of care.

24 “(4) TERMINATED.—The term ‘terminated’ in-
25 cludes, with respect to a contract (as defined in

1 paragraph (1)), the expiration or nonrenewal of the
2 contract by the group health plan or the health in-
3 surance issuer, but does not include a termination of
4 the contract by the plan or issuer for failure to meet
5 applicable quality standards or for fraud.

6 **SEC. 727. PROHIBITION OF INTERFERENCE WITH CERTAIN**
7 **MEDICAL COMMUNICATIONS.**

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

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

1 **“SEC. 728. PATIENT’S RIGHT TO PRESCRIPTION DRUGS.**

2 “To the extent that a group health plan, or health
3 insurance coverage offered by a health insurance issuer
4 in connection with such a plan, provides coverage for bene-
5 fits with respect to prescription drugs, and limits such cov-
6 erage to drugs included in a formulary, the plan or issuer
7 shall—

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

11 “(2) disclose the nature of such limits on such
12 coverage to providers whose services (or reimburse-
13 ment therefor) are included under the coverage of
14 the plan (in addition to disclosure to participants
15 and beneficiaries upon request in accordance with
16 section 714(c)(3)), and

17 “(3) in accordance with the applicable quality
18 assurance and utilization review standards of the
19 plan or issuer, provide for exceptions from the for-
20 mulary limitation when a non-formulary alternative
21 is medically necessary and appropriate.

22 **“SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE**
23 **SERVICES.**

24 “(a) IN GENERAL.—A group health plan, and a
25 health insurance issuer in relation to its offering of health

1 insurance coverage in connection with such a plan, may
2 not—

3 “(1) prohibit or otherwise discourage a partici-
4 pant or beneficiary from self-paying for behavioral
5 health care services once the plan or issuer has de-
6 nied coverage for such services; or

7 “(2) terminate a health care provider because
8 such provider permits participants or beneficiaries to
9 self-pay for behavioral health care services—

10 “(A) that are not otherwise covered under
11 the plan or coverage; or

12 “(B) for which the group health plan or
13 coverage provides limited coverage, to the ex-
14 tent that the plan or issuer denies coverage of
15 the services.

16 “(b) **RULE OF CONSTRUCTION.**—Nothing in sub-
17 section (a)(2)(B) shall be construed as prohibiting a group
18 health plan or health insurance issuer from terminating
19 a contract with a health care provider for failure to meet
20 applicable quality standards or for fraud.

21 **“SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**
22 **APPROVED CANCER CLINICAL TRIALS.**

23 “(a) **COVERAGE.**—

24 “(1) **IN GENERAL.**—If a group health plan, or
25 a health insurance issuer offering health insurance

1 coverage in connection with such a plan, provides
2 coverage to a qualified individual (as defined in sub-
3 section (b)), the plan or issuer—

4 “(A) may not deny the individual partici-
5 pation in the clinical trial referred to in sub-
6 section (b)(2);

7 “(B) subject to subsections (b), (c), and
8 (d), may not deny (or limit or impose additional
9 conditions on) the coverage of routine patient
10 costs for items and services furnished in con-
11 nection with participation in the trial; and

12 “(C) may not discriminate against the in-
13 dividual on the basis of the individual’s partici-
14 pation in such trial.

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

20 “(3) USE OF IN-NETWORK PROVIDERS.—If one
21 or more participating providers is participating in a
22 clinical trial, nothing in paragraph (1) shall be con-
23 strued as preventing a plan or issuer from requiring
24 that a qualified individual participate in the trial
25 through such a participating provider if the provider

1 will accept the individual as a participant in the
2 trial.

3 “(b) QUALIFIED INDIVIDUAL DEFINED.—For pur-
4 poses of subsection (a), the term ‘qualified individual’
5 means an individual who is a participant or beneficiary
6 in a group health plan who meets the following conditions:

7 “(1)(A) The individual has been diagnosed with
8 cancer.

9 “(B) The individual is eligible to participate in
10 an approved clinical trial according to the trial pro-
11 tocol with respect to treatment of such illness.

12 “(C) The individual’s participation in the trial
13 offers meaningful potential for significant clinical
14 benefit for the individual.

15 “(2) Either—

16 “(A) the referring physician is a partici-
17 pating health care professional and has con-
18 cluded that the individual’s participation in
19 such trial would be appropriate based upon the
20 individual meeting the conditions described in
21 paragraph (1); or

22 “(B) the individual provides medical and
23 scientific information establishing that the indi-
24 vidual’s participation in such trial would be ap-

1 appropriate based upon the individual meeting the
2 conditions described in paragraph (1).

3 “(c) PAYMENT.—

4 “(1) IN GENERAL.—Under this section a group
5 health plan (or health insurance issuer offering
6 health insurance) shall provide for payment for rou-
7 tine patient costs described in subsection (a)(2) but
8 is not required to pay for costs of items and services
9 that are reasonably expected to be paid for by the
10 sponsors of an approved clinical trial.

11 “(2) ROUTINE PATIENT CARE COSTS.—For pur-
12 poses of this section—

13 “(A) IN GENERAL.—The term ‘routine pa-
14 tient care costs’ includes the costs associated
15 with the provision of items and services that—

16 “(i) would otherwise be covered under
17 the group health plan if such items and
18 services were not provided in connection
19 with an approved clinical trial program;
20 and

21 “(ii) are furnished according to the
22 protocol of an approved clinical trial pro-
23 gram.

24 “(B) EXCLUSION.—Such term does include
25 the costs associated with the provision of—

1 “(i) an investigational drug or device,
2 unless the Secretary has authorized the
3 manufacturer of such drug or device to
4 charge for such drug or device; or

5 “(ii) any item or service supplied
6 without charge by the sponsor of the ap-
7 proved clinical trial program.

8 “(3) PAYMENT RATE.—In the case of covered
9 items and services provided by—

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

12 “(B) a nonparticipating provider, the pay-
13 ment rate shall be at the rate the plan or issuer
14 would normally pay for comparable items or
15 services under subparagraph (A).

16 “(d) APPROVED CLINICAL TRIAL DEFINED.—In this
17 section, the term ‘approved clinical trial’ means a cancer
18 clinical research study or cancer clinical investigation ap-
19 proved by an Institutional Review Board.

20 “(e) CONSTRUCTION.—Nothing in this section shall
21 be construed to limit a plan’s or issuer’s coverage with
22 respect to clinical trials.

23 “(f) PLAN SATISFACTION OF CERTAIN REQUIRE-
24 MENTS; RESPONSIBILITIES OF FIDUCIARIES.—

1 “(1) IN GENERAL.—For purposes of this sec-
2 tion, insofar as a group health plan provides benefits
3 in the form of health insurance coverage through a
4 health insurance issuer, the plan shall be treated as
5 meeting the requirements of this section with respect
6 to such benefits and not be considered as failing to
7 meet such requirements because of a failure of the
8 issuer to meet such requirements so long as the plan
9 sponsor or its representatives did not cause such
10 failure by the issuer.

11 “(2) CONSTRUCTION.—Nothing in this section
12 shall be construed to affect or modify the respon-
13 sibilities of the fiduciaries of a group health plan
14 under part 4 of subtitle B.

15 **“SEC. 730A. PROHIBITION OF DISCRIMINATION AGAINST**
16 **PROVIDERS BASED ON LICENSURE.**

17 “(a) IN GENERAL.—A group health plan, and a
18 health insurance issuer in relation to its offering of health
19 insurance coverage in connection with such a plan, shall
20 not discriminate with respect to participation or indem-
21 nification as to any provider who is acting within the scope
22 of the provider’s license or certification under applicable
23 State law, solely on the basis of such license or certifi-
24 cation.

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

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

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

14 “(3) as requiring a plan or issuer that offers
15 network coverage to include for participation every
16 willing provider who meets the terms and conditions
17 of the plan or issuer; or

18 “(4) as prohibiting a family practice physician
19 with appropriate expertise from providing pediatric
20 or obstetric or gynecological care.

21 **“SEC. 730B. PROHIBITION AGAINST IMPROPER INCENTIVE**
22 **ARRANGEMENTS.**

23 “(a) IN GENERAL.—A group health plan and a health
24 insurance issuer offering health insurance coverage in con-
25 nection with such a plan may not operate any physician

1 incentive plan (as defined in subparagraph (B) of section
2 1876(i)(8) of the Social Security Act) unless the require-
3 ments described in clauses (i), (ii)(I), and (iii) of subpara-
4 graph (A) of such section are met with respect to such
5 a plan.

6 “(b) APPLICATION.—For purposes of carrying out
7 paragraph (1), any reference in section 1876(i)(8) of the
8 Social Security Act to the Secretary, an eligible organiza-
9 tion, or an individual enrolled with the organization shall
10 be treated as a reference to the applicable authority, a
11 group health plan or health insurance issuer, respectively,
12 and a participant or beneficiary with the plan or organiza-
13 tion, respectively.

14 “(c) CONSTRUCTION.—Nothing in this section shall
15 be construed as prohibiting all capitation and similar ar-
16 rangements or all provider discount arrangements.

17 **“SEC. 730C. PAYMENT OF CLEAN CLAIMS.**

18 “A group health plan, and a health insurance issuer
19 offering group health insurance coverage, shall provide for
20 prompt payment of claims submitted for health care serv-
21 ices or supplies furnished to a participant or beneficiary
22 with respect to benefits covered by the plan or issuer, in
23 a manner consistent with the provisions of sections
24 1816(c)(2) and 1842(c)(2) of the Social Security Act (42
25 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except

1 that for purposes of this section, subparagraph (C) of sec-
2 tion 1816(c)(2) of the Social Security Act shall be treated
3 as applying to claims received from a participant or bene-
4 ficiary as well as claims referred to in such subparagraph.

5 **“SEC. 730D. GENERALLY APPLICABLE PROVISION.**

6 “In the case of a group health plan or health insur-
7 ance coverage that provides benefits under 2 or more cov-
8 erage options, the requirements of this subpart shall apply
9 separately with respect to each coverage option.

10 **“SEC. 730E. EXCLUSION FROM ACCESS TO MANAGED CARE**

11 **PROVISIONS FOR FEE-FOR-SERVICE COV-**
12 **ERAGE.**

13 “(a) IN GENERAL.—The provisions of sections 721
14 through 730D shall not apply to a group health plan or
15 health insurance coverage if the only coverage offered
16 under the plan or coverage is fee-for-service coverage (as
17 defined in subsection (b)).

18 “(b) FEE-FOR-SERVICE COVERAGE DEFINED.—For
19 purposes of this section, the term ‘fee-for-service coverage’
20 means coverage under a group health plan or health insur-
21 ance coverage that—

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

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

5 “(3) allows access to any provider that is law-
6 fully authorized to provide the covered services and
7 that agrees to accept the terms and conditions of
8 payment established under the plan or by the issuer;
9 and

10 “(4) for which the plan or issuer does not re-
11 quire prior authorization before providing for any
12 health care services.

13 **“SEC. 730F. ADDITIONAL DEFINITIONS.**

14 “For purposes of this subpart, section 714, and sec-
15 tions 503A through 503D:

16 “(1) **APPLICABLE AUTHORITY.**—The term ‘ap-
17 plicable authority’ means—

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

21 “(B) in the case of a health insurance
22 issuer with respect to a specific provision of this
23 subpart, the applicable State authority (as de-
24 fined in section 2791(d) of the Public Health
25 Service Act), or the Secretary of Health and

1 Human Services, if such Secretary is enforcing
2 such provision under section 2722(a)(2) or
3 2761(a)(2) of the Public Health Service Act.

4 “(2) GROUP HEALTH PLAN.—The term ‘group
5 health plan’ has the meaning given such term in sec-
6 tion 733(a), except that such term includes a em-
7 ployee welfare benefit plan treated as a group health
8 plan under section 732(d) or defined as such a plan
9 under section 607(1).

10 “(3) HEALTH CARE PROFESSIONAL.—The term
11 ‘health care professional’ means an individual who is
12 licensed, accredited, or certified under State law to
13 provide specified health care services and who is op-
14 erating within the scope of such licensure, accredita-
15 tion, or certification.

16 “(4) HEALTH CARE PROVIDER.—The term
17 ‘health care provider’ includes an allopathic or osteo-
18 pathic physician or other health care professional, as
19 well as an institutional or other facility or agency
20 that provides health care services and that is li-
21 censed, accredited, or certified to provide health care
22 items and services under applicable State law.

23 “(5) NETWORK.—The term ‘network’ means,
24 with respect to a group health plan or health insur-
25 ance issuer offering health insurance coverage, the

1 participating health care professionals and providers
2 through whom the plan or issuer provides health
3 care items and services to participants or bene-
4 ficiaries.

5 “(6) NONPARTICIPATING.—The term ‘non-
6 participating’ means, with respect to a health care
7 provider that provides health care items and services
8 to a participant or beneficiary under group health
9 plan or health insurance coverage, a health care pro-
10 vider that is not a participating health care provider
11 with respect to such items and services.

12 “(7) PARTICIPATING.—The term ‘participating’
13 means, with respect to a health care provider that
14 provides health care items and services to a partici-
15 pant or beneficiary under group health plan or
16 health insurance coverage offered by a health insur-
17 ance issuer, a health care provider that furnishes
18 such items and services under a contract or other
19 arrangement with the plan or issuer.

20 “(8) PRIOR AUTHORIZATION.—The term ‘prior
21 authorization’ means the process of obtaining prior
22 approval from a health insurance issuer or group
23 health plan for the provision or coverage of medical
24 services.

1 “(9) TERMS AND CONDITIONS.—The term
2 ‘terms and conditions’ includes, with respect to a
3 group health plan or health insurance coverage, re-
4 quirements imposed under this subpart (and section
5 714 and sections 503A through 503D) with respect
6 to the plan or coverage.”.

7 (b) RULE WITH RESPECT TO CERTAIN PLANS.—

8 (1) IN GENERAL.—Notwithstanding any other
9 provision of law, health insurance issuers may offer,
10 and eligible individuals may purchase, high deduct-
11 ible health plans described in section 220(c)(2)(A) of
12 the Internal Revenue Code of 1986. Effective for the
13 5-year period beginning on the date of the enact-
14 ment of this Act, such health plans shall not be re-
15 quired to provide payment for any health care items
16 or services that are exempt from the plan’s deduct-
17 ible.

18 (2) EXISTING STATE LAWS.—A State law relat-
19 ing to payment for health care items and services in
20 effect on the date of enactment of this Act that is
21 preempted under paragraph (1), shall not apply to
22 high deductible health plans after the expiration of
23 the 5-year period described in such paragraph unless
24 the State reenacts such law after such period.

1 (c) CONFORMING AMENDMENT.—The table of con-
 2 tents in section 1 of the Employee Retirement Income Se-
 3 curity Act of 1974 is amended—

4 (1) in the item relating to subpart C of part 7
 5 of subtitle B of title I, by striking “Subpart C” and
 6 inserting “Subpart D”; and

7 (2) by adding at the end of the items relating
 8 to subpart B of part 7 of subtitle B of title I, the
 9 following:

“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 721. Access to emergency medical care.

“Sec. 722. Offering of choice of coverage options.

“Sec. 723. Patient access to obstetric and gynecological care.

“Sec. 724. Access to pediatric care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

“Sec. 727. Protection of patient-provider communications.

“Sec. 728. Patient’s right to prescription drugs.

“Sec. 729. Self-payment for behavioral health care services.

“Sec. 730. Coverage for individuals participating in approved cancer clinical
 trials.

“Sec. 730B. Prohibition against improper incentive arrangements.

“Sec. 730C. Payment of clean claims.

“Sec. 730D. Generally applicable provision.”.

10 **SEC. 102. CONFORMING AMENDMENTS TO THE PUBLIC**
 11 **HEALTH SERVICE ACT.**

12 (a) GROUP HEALTH PLANS.—Title XXVII of the
 13 Public Health Service Act is amended by inserting after
 14 section 2706 the following new section:

15 **“SEC. 2707. STANDARD RELATING TO PATIENTS’ BILL OF**
 16 **RIGHTS.**

17 “Subject to section 2724, a group health plan, and
 18 health insurance coverage offered in connection with a

1 group health plan, shall comply with the requirements of
2 subpart C of part 7 of subtitle B of title I of the Employee
3 Retirement Income Security Act of 1974 (as in effect as
4 of the date of the enactment of such Act) and such re-
5 quirements shall be deemed to be incorporated into this
6 section.”.

7 (b) INDIVIDUAL HEALTH PLANS.—Title XXVII of
8 the Public Health Service Act is amended by inserting
9 after section 2752 the following new section:

10 **“SEC. 2753. STANDARD RELATING TO PATIENTS’ BILL OF**
11 **RIGHTS.**

12 “The provisions of section 2706 shall apply to health
13 insurance coverage offered by a health insurance issuer
14 in the individual market for an enrollee in the same man-
15 ner as they apply to health insurance coverage offered by
16 a health insurance issuer in connection with a group
17 health plan for a participant or beneficiary in the small
18 or large group market and the requirements referred to
19 in such section shall be deemed to be incorporated into
20 this section.”.

21 **SEC. 103. CONFORMING AMENDMENTS TO THE INTERNAL**
22 **REVENUE CODE OF 1986.**

23 Subchapter B of chapter 100 of the Internal Revenue
24 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 patients’ bill of rights.”;

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 subpart C of part 7 of subtitle B of title I of
 11 the Employee Retirement Income Security Act of 1974 (as
 12 in effect as of the date of the enactment of such Act) and
 13 such requirements shall be deemed to be incorporated into
 14 this section.”.

15 **Subtitle B—Right to Information**
 16 **About Plans and Providers**

17 **SEC. 111. INFORMATION ABOUT PLANS AND COVERAGE**
 18 **UNDER ERISA.**

19 (a) EMPLOYEE RETIREMENT INCOME SECURITY ACT
 20 OF 1974.—Subpart B of part 7 of subtitle B of title I
 21 of the Employee Retirement Income Security Act of 1974
 22 (29 U.S.C. 1185 et seq.) is amended by adding at the end
 23 the following:

24 **“SEC. 714. PATIENT ACCESS TO INFORMATION.**

25 **“(a) DISCLOSURE REQUIREMENT.—**

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

3 “(A) provide to participants and bene-
4 ficiaries at the time of initial coverage under
5 the plan (or the effective date of this section, in
6 the case of individuals who are participants or
7 beneficiaries as of such date), and at least an-
8 nually thereafter, the information described in
9 subsection (b);

10 “(B) provide to participants and bene-
11 ficiaries, within a reasonable period (as speci-
12 fied by the Secretary) before or after the date
13 of significant changes in the information de-
14 scribed in subsection (b), information on such
15 significant changes; and

16 “(C) upon request, make available to par-
17 ticipants and beneficiaries, the Secretary, and
18 prospective participants and beneficiaries, the
19 information described in subsection (b) or (c).

20 The plan may charge a reasonable fee for provision
21 in printed form of any of the information described
22 in subsection (b) or (c) more than once during any
23 plan year.

24 “(2) HEALTH INSURANCE ISSUERS.—A health
25 insurance issuer in connection with the provision of

1 health insurance coverage in connection with a group
2 health plan shall—

3 “(A) provide to participants and bene-
4 ficiaries enrolled under such coverage at the
5 time of enrollment, and at least annually there-
6 after, the information described in subsection
7 (b);

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

14 “(C) upon request, make available to the
15 Secretary, to individuals who are prospective
16 participants and beneficiaries, and to the public
17 the information described in subsection (b) or
18 (c).

19 “(3) EMPLOYERS.—Effective 5 years after the
20 date this part first becomes effective, each employer
21 (other than an employer described in paragraph (1)
22 of subsection (d)) shall provide to each employee at
23 least annually information (consistent with such sub-
24 section) on the amount that the employer contrib-

1 utes on behalf of the employee (and any dependents
2 of the employee) for health benefits coverage.

3 “(b) INFORMATION PROVIDED.—The information de-
4 scribed in this subsection with respect to a group health
5 plan or health insurance coverage offered by a health in-
6 surance issuer shall be provided to a participant or bene-
7 ficiary free of charge at least once a year and includes
8 the following:

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

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

13 “(A) those that are covered benefits, limits
14 and conditions on such benefits, and those ben-
15 efits that are explicitly excluded from coverage;

16 “(B) cost sharing, such as deductibles, co-
17 insurance, and copayment amounts, including
18 any liability for balance billing, any maximum
19 limitations on out of pocket expenses, and the
20 maximum out of pocket costs for services that
21 are provided by nonparticipating providers or
22 that are furnished without meeting the applica-
23 ble utilization review requirements;

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

1 “(D) the extent to which a participant or
2 beneficiary may select from among participating
3 providers and the types of providers partici-
4 pating in the plan or issuer network;

5 “(E) process for determining experimental
6 coverage;

7 “(F) use of a prescription drug formulary
8 (if any); and

9 “(G) any definition of medical necessity
10 used in making coverage determinations by the
11 plan, issuer, or claims administrator.

12 “(3) ACCESS.—A description of the following:

13 “(A) The number, mix, and distribution of
14 providers under the plan or coverage.

15 “(B) Out-of-network coverage (if any) pro-
16 vided by the plan or coverage.

17 “(C) Any point-of-service option (including
18 any supplemental premium or cost-sharing for
19 such option).

20 “(D) The procedures for participants and
21 beneficiaries to select, access, and change par-
22 ticipating primary and specialty providers.

23 “(E) The rights and procedures for obtain-
24 ing referrals (including standing referrals) to
25 participating and nonparticipating providers.

1 “(F) The name, address, and telephone
2 number of participating health care providers
3 and an indication of whether each such provider
4 is available to accept new patients.

5 “(G) Any limitations imposed on the selec-
6 tion of qualifying participating health care pro-
7 viders, including any limitations imposed under
8 section 812(b)(2).

9 “(4) OUT-OF-AREA COVERAGE.—Out-of-area
10 coverage provided by the plan or issuer.

11 “(5) EMERGENCY COVERAGE.—Coverage of
12 emergency services, including—

13 “(A) the appropriate use of emergency
14 services, including use of the 911 telephone sys-
15 tem or its local equivalent in emergency situa-
16 tions and an explanation of what constitutes an
17 emergency situation;

18 “(B) the process and procedures of the
19 plan or issuer for obtaining emergency services;
20 and

21 “(C) the locations of (i) emergency depart-
22 ments, and (ii) other settings, in which plan
23 physicians and hospitals provide emergency
24 services and post-stabilization care.

1 “(6) PRIOR AUTHORIZATION RULES.—Rules re-
2 garding prior authorization or other review require-
3 ments that could result in noncoverage or non-
4 payment.

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

11 “(8) ACCOUNTABILITY.—A description of the
12 legal recourse options available for participants and
13 beneficiaries under the plan including—

14 “(A) the preemption that applies under
15 section 514 to certain actions arising out of the
16 provision of health benefits; and

17 “(B) the extent to which coverage decisions
18 made by the plan are subject to internal review
19 or any external review and the proper time
20 frames under

21 “(9) QUALITY ASSURANCE.—Any information
22 made public by an accrediting organization in the
23 process of accreditation of the plan or issuer or any
24 additional quality indicators the plan or issuer
25 makes available.

1 “(10) INFORMATION ON ISSUER.—Notice of ap-
2 propriate mailing addresses and telephone numbers
3 to be used by participants and beneficiaries in seek-
4 ing information or authorization for treatment.

5 “(11) AVAILABILITY OF INFORMATION ON RE-
6 QUEST.—Notice that the information described in
7 subsection (c) is available upon request.

8 “(c) INFORMATION MADE AVAILABLE UPON RE-
9 QUEST.—The information described in this subsection is
10 the following:

11 “(1) UTILIZATION REVIEW ACTIVITIES.—A de-
12 scription of procedures used and requirements (in-
13 cluding circumstances, time frames, and appeal
14 rights) under any utilization review program under
15 section 801.

16 “(2) GRIEVANCE AND APPEALS INFORMA-
17 TION.—Information on the number of grievances
18 and appeals and on the disposition in the aggregate
19 of such matters.

20 “(3) FORMULARY RESTRICTIONS.—A descrip-
21 tion of the nature of any drug formulary restric-
22 tions.

23 “(4) PARTICIPATING PROVIDER LIST.—A list of
24 current participating health care providers.

25 “(d) EMPLOYER INFORMATION.—

1 “(1) SMALL EMPLOYER EXEMPTION.—Sub-
2 section (a)(3) shall not apply to an employer that is
3 a small employer (as defined in section
4 712(c)(1)(B)) or would be such an employer if ‘100’
5 were substituted for ‘50’ in such section.

6 “(2) COMPUTATION.—The amount described in
7 subsection (a)(3) may be computed on an average,
8 per employee basis, and may be based on rules simi-
9 lar to the rules applied in computing the applicable
10 premium under section 604.

11 “(3) FORM OF DISCLOSURE.—The information
12 under subsection (a)(3) may be provided in any rea-
13 sonable form, including as part of the summary plan
14 description, a letter, or information accompanying a
15 W-2 form.

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

20 (b) CONFORMING AMENDMENTS.—

21 (1) Section 732(a) of the Employee Retirement
22 Income Security Act of 1974 (29 U.S.C. 1191a(a))
23 is amended by striking “section 711” and inserting
24 “sections 711 and 714”.

1 (2) The table of contents in section 1 of the
2 Employee Retirement Income Security Act of 1974
3 (29 U.S.C. 1001) is amended by inserting after the
4 item relating to section 713, the following:

“Sec 714. Patient access to information.”.

5 (3) Section 502(b)(3) of the Employee Retirement
6 Income Security Act of 1974 (29 U.S.C.
7 1132(b)(3)) is amended by striking “733(a)(1)”
8 and inserting “733(a)(1), except with respect to the
9 requirements of section 714”.

10 **SEC. 112. CONFORMING AMENDMENTS TO PUBLIC HEALTH**
11 **SERVICE ACT.**

12 (a) GROUP HEALTH PLANS.—Title XXVII of the
13 Public Health Service Act, as amended by section 102(a),
14 is amended by inserting after section 2707 the following
15 new section:

16 **“SEC. 2708. STANDARD RELATING TO PATIENT ACCESS TO**
17 **INFORMATION.**

18 “A group health plan, and health insurance coverage
19 offered in connection with a group health plan, shall com-
20 ply with the requirements of section 714 of the Employee
21 Retirement Income Security Act of 1974 (as in effect as
22 of the date of the enactment of such Act) and such re-
23 quirements shall be deemed to be incorporated into this
24 section.”.

1 (b) INDIVIDUAL HEALTH PLANS.—Title XXVII of
2 the Public Health Service Act, as amended by section
3 102(b), is amended by inserting after section 2753 the fol-
4 lowing new section:

5 **“SEC. 2754. STANDARD RELATING TO PATIENT ACCESS TO**
6 **INFORMATION.**

7 “The provisions of section 2707 shall apply to health
8 insurance coverage offered by a health insurance issuer
9 in the individual market for an enrollee in the same man-
10 ner as they apply to health insurance coverage offered by
11 a health insurance issuer in connection with a group
12 health plan for a participant or beneficiary in the small
13 or large group market and the requirements referred to
14 in such section shall be deemed to be incorporated into
15 this section.”.

16 **SEC. 113. CONFORMING AMENDMENTS TO THE INTERNAL**
17 **REVENUE CODE OF 1986.**

18 Subchapter B of chapter 100 of the Internal Revenue
19 Code of 1986, as amended by section 103, is amended—

20 (1) in the table of sections, by inserting after
21 the item relating to section 9813 the following new
22 item:

“Sec. 9814. Standard relating to patient access to information.”;

23 and

24 (2) by inserting after section 9812 the fol-
25 lowing:

1 **“SEC. 9814. STANDARD RELATING TO PATIENT ACCESS TO**
2 **INFORMATION.**

3 “A group health plan shall comply with the require-
4 ments of section 714 of the Employee Retirement Income
5 Security Act of 1974 (as in effect as of the day after the
6 date of the enactment of such Act) and such requirements
7 shall be deemed to be incorporated into this section.”.

8 **Subtitle C—Right to Hold Health**
9 **Plans Accountable**

10 **SEC. 121. AMENDMENTS TO EMPLOYEE RETIREMENT IN-**
11 **COME SECURITY ACT OF 1974.**

12 (a) IN GENERAL.—Part 5 of subtitle B of title I of
13 the Employee Retirement Income Security Act of 1974 is
14 amended by inserting after section 503 (29 U.S.C. 1133)
15 the following new sections:

16 **“SEC. 503A. UTILIZATION REVIEW ACTIVITIES.**

17 “(a) COMPLIANCE WITH REQUIREMENTS.—

18 “(1) IN GENERAL.—A group health plan, and a
19 health insurance issuer that provides health insur-
20 ance coverage, shall conduct utilization review activi-
21 ties in connection with the provision of benefits
22 under such plan or coverage only in accordance with
23 a utilization review program that meets the require-
24 ments of this section and section 503B.

25 “(2) USE OF OUTSIDE AGENTS.—Nothing in
26 this section shall be construed as preventing a group

1 health plan or health insurance issuer from arrang-
2 ing through a contract or otherwise for persons or
3 entities to conduct utilization review activities on be-
4 half of the plan or issuer, so long as such activities
5 are conducted in accordance with a utilization review
6 program that meets the requirements of this section.

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

16 “(b) WRITTEN POLICIES AND CRITERIA.—

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

21 “(2) USE OF WRITTEN CRITERIA.—

22 “(A) IN GENERAL.—Such a program shall
23 utilize written clinical review criteria developed
24 with input from a range of appropriate actively
25 practicing physicians or dentists, as determined

1 by the plan, pursuant to the program. Such cri-
2 teria shall include written clinical review criteria
3 that are based on valid clinical evidence where
4 available and that are directed specifically at
5 meeting the needs of at-risk populations and
6 covered individuals with chronic conditions or
7 severe illnesses, including gender-specific cri-
8 teria and pediatric-specific criteria where avail-
9 able and appropriate.

10 “(B) CONTINUING USE OF STANDARDS IN
11 RETROSPECTIVE REVIEW.—If a health care
12 service has been specifically pre-authorized or
13 approved for a participant or beneficiary under
14 such a program, the program shall not, pursu-
15 ant to retrospective review, revise or modify the
16 specific standards, criteria, or procedures used
17 for the utilization review for procedures, treat-
18 ment, and services delivered to the participant
19 or beneficiary during the same course of treat-
20 ment.

21 “(C) REVIEW OF SAMPLE OF CLAIMS DE-
22 NIALS.—Such a program shall provide for an
23 evaluation of the clinical appropriateness of at
24 least a sample of denials of claims for benefits.

25 “(c) CONDUCT OF PROGRAM ACTIVITIES.—

1 “(1) ADMINISTRATION BY PHYSICIANS OR DEN-
2 TISTS.—A utilization review program shall be ad-
3 ministered by qualified physicians or dentists who
4 shall oversee review decisions.

5 “(2) USE OF QUALIFIED, INDEPENDENT PER-
6 SONNEL.—

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

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

20 “(C) PROHIBITION OF CONFLICTS.—Such
21 a program shall not permit a health care pro-
22 fessional who is providing health care services
23 to an individual to perform utilization review
24 activities in connection with the health care
25 services being provided to the individual.

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

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

16 **“SEC. 503B. PROCEDURES FOR INITIAL CLAIMS FOR BENE-**
17 **FITS AND PRIOR AUTHORIZATION DETER-**
18 **MINATIONS.**

19 “(a) PROCEDURES OF INITIAL CLAIMS FOR BENE-
20 FITS.—

21 “(1) IN GENERAL.—A group health plan, or
22 health insurance issuer offering health insurance
23 coverage in connection with a group health plan,
24 shall—

1 “(A) make a determination on an initial
2 claim for benefits by a participant or bene-
3 ficiary (or authorized representative) regarding
4 payment or coverage for items or services under
5 the terms and conditions of the plan or cov-
6 erage involved, including any cost-sharing
7 amount that the participant or beneficiary is re-
8 quired to pay with respect to such claim for
9 benefits; and

10 “(B) notify a participant or beneficiary (or
11 authorized representative) and the treating
12 health care professional involved regarding a
13 determination on an initial claim for benefits
14 made under the terms and conditions of the
15 plan or coverage, including any cost-sharing
16 amounts that the participant or beneficiary may
17 be required to make with respect to such claim
18 for benefits, and of the right of the participant
19 or beneficiary to an internal appeal under sec-
20 tion 503C.

21 “(2) ACCESS TO INFORMATION.—With respect
22 to an initial claim for benefits, the participant or
23 beneficiary (or authorized representative) and the
24 treating health care professional (if any) shall pro-
25 vide the plan or issuer with access to information re-

1 requested by the plan or issuer that is necessary to
2 make a determination relating to the claim. Such ac-
3 cess shall be provided not later than 5 days after the
4 date on which the request for information is re-
5 ceived, or, in a case described in subparagraph (B)
6 or (C) of subsection (b)(1), by such earlier time as
7 may be necessary to comply with the applicable
8 timeline under such subparagraph.

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

24 “(b) TIMELINE FOR MAKING DETERMINATIONS.—

1 “(1) PRIOR AUTHORIZATION DETERMINA-
2 TION.—

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

17 “(B) EXPEDITED DETERMINATION.—Not-
18 withstanding subparagraph (A), a group health
19 plan, or health insurance issuer offering health
20 insurance coverage in connection with a group
21 health plan, shall expedite a prior authorization
22 determination on a claim for benefits described
23 in such subparagraph when a request for such
24 an expedited determination is made by a partic-
25 ipant or beneficiary (or authorized representa-

1 tive) at any time during the process for making
2 a determination and a health care professional
3 certifies, with the request, that a determination
4 under the procedures described in subparagraph
5 (A) would seriously jeopardize the life or health
6 of the participant or beneficiary or the ability of
7 the participant or beneficiary to maintain or re-
8 gain maximum function. Such determination
9 shall be made as soon as possible based on the
10 medical exigencies of the case involved and in
11 no case later than 72 hours after the time the
12 request is received by the plan or issuer under
13 this subparagraph.

14 “(C) ONGOING CARE.—

15 “(i) CONCURRENT REVIEW.—

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

1 care provider as soon as possible in
2 accordance with the medical exigen-
3 cies of the case, with sufficient time
4 prior to the termination or reduction
5 to allow for an appeal under section
6 503C(b)(3) to be completed before the
7 termination or reduction takes effect.

8 “(II) CONTENTS OF NOTICE.—

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

17 “(ii) RULE OF CONSTRUCTION.—

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

22 “(2) RETROSPECTIVE DETERMINATION.—A

23 group health plan, or health insurance issuer offer-
24 ing health insurance coverage in connection with a
25 group health plan, shall make a retrospective deter-

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

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

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

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

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

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

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

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

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

23 “(3) DENIAL OF CLAIM FOR BENEFITS.—The
24 term ‘denial’ means, with respect to a claim for ben-
25 efits, a denial (in whole or in part) of, or a failure

1 to act on a timely basis upon, the claim for benefits
2 and includes a failure to provide benefits (including
3 items and services) required to be provided under
4 this title.

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

11 **“SEC. 503C. INTERNAL APPEALS OF CLAIMS DENIALS.**

12 “(a) RIGHT TO INTERNAL APPEAL.—

13 “(1) IN GENERAL.—A participant or beneficiary
14 of a group health plan (or authorized representative)
15 may appeal any denial of a claim for benefits under
16 section 503B under the procedures described in this
17 section.

18 “(2) TIME FOR APPEAL.—

19 “(A) IN GENERAL.—A group health plan,
20 or health insurance issuer offering health insur-
21 ance coverage in connection with a group health
22 plan, shall ensure that a participant or bene-
23 ficiary (or authorized representative) has a pe-
24 riod of not less than 180 days beginning on the
25 date of a denial of a claim for benefits under

1 section 503B in which to appeal such denial
2 under this section.

3 “(B) DATE OF DENIAL.—For purposes of
4 subparagraph (A), the date of the denial shall
5 be deemed to be the date as of which the partic-
6 ipant or beneficiary knew of the denial of the
7 claim for benefits.

8 “(3) FAILURE TO ACT.—The failure of a plan
9 or issuer to issue a determination on a claim for
10 benefits under section 503B within the applicable
11 timeline established for such a determination under
12 such section is a denial of a claim for benefits for
13 purposes this section and section 503D as of the
14 date of the applicable deadline.

15 “(4) PLAN WAIVER OF INTERNAL REVIEW.—A
16 group health plan, or health insurance issuer offer-
17 ing health insurance coverage in connection with a
18 group health plan, may waive the internal review
19 process under this section. In such case the plan or
20 issuer shall provide notice to the participant or bene-
21 ficiary (or authorized representative) involved, the
22 participant or beneficiary (or authorized representa-
23 tive) involved shall be relieved of any obligation to
24 complete the internal review involved, and may, at
25 the option of such participant, beneficiary, or rep-

1 representative proceed directly to seek further appeal
2 through external review under section 503D or oth-
3 erwise.

4 “(b) TIMELINES FOR MAKING DETERMINATIONS.—

5 “(1) ORAL REQUESTS.—In the case of an ap-
6 peal of a denial of a claim for benefits under this
7 section that involves an expedited or concurrent de-
8 termination, a participant or beneficiary (or author-
9 ized representative) may request such appeal orally.
10 A group health plan, or health insurance issuer of-
11 fering health insurance coverage in connection with
12 a group health plan, may require that the partici-
13 pant or beneficiary (or authorized representative)
14 provide written confirmation of such request in a
15 timely manner on a form provided by the plan or
16 issuer. In the case of such an oral request for an ap-
17 peal of a denial, the making of the request (and the
18 timing of such request) shall be treated as the mak-
19 ing at that time of a request for an appeal without
20 regard to whether and when a written confirmation
21 of such request is made.

22 “(2) ACCESS TO INFORMATION.—With respect
23 to an appeal of a denial of a claim for benefits, the
24 participant or beneficiary (or authorized representa-
25 tive) and the treating health care professional (if

1 any) shall provide the plan or issuer with access to
2 information requested by the plan or issuer that is
3 necessary to make a determination relating to the
4 appeal. Such access shall be provided not later than
5 5 days after the date on which the request for infor-
6 mation is received, or, in a case described in sub-
7 paragraph (B) or (C) of paragraph (3), by such ear-
8 lier time as may be necessary to comply with the ap-
9 plicable timeline under such subparagraph.

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

12 “(A) IN GENERAL.—A group health plan,
13 or health insurance issuer offering health insur-
14 ance coverage in connection with a group health
15 plan, shall make a determination on an appeal
16 of a denial of a claim for benefits under this
17 subsection as soon as possible in accordance
18 with the medical exigencies of the case but in
19 no case later than 14 days from the date on
20 which the plan or issuer receives information
21 that is reasonably necessary to enable the plan
22 or issuer to make a determination on the appeal
23 and in no case later than 28 days after the date
24 the request for the appeal is received.

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

24 “(C) ONGOING CARE DETERMINATIONS.—

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

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

22 “(4) RETROSPECTIVE DETERMINATION.—A
23 group health plan, or health insurance issuer offer-
24 ing health insurance coverage in connection with a
25 group health plan, shall make a retrospective deter-

1 mination on an appeal of a claim for benefits in no
2 case later than 30 days after the date on which the
3 plan or issuer receives necessary information that is
4 reasonably necessary to enable the plan or issuer to
5 make a determination on the appeal and in no case
6 later than 60 days after the date the request for the
7 appeal is received.

8 “(c) CONDUCT OF REVIEW.—

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

13 “(2) APPROPRIATE REVIEW OF MEDICAL DECI-
14 SIONS.—A review of an appeal of a denial of a claim
15 for benefits that is based on a lack of medical neces-
16 sity and appropriateness, or based on an experi-
17 mental or investigational treatment, or requires an
18 evaluation of medical facts, shall be made by a phy-
19 sician (allopathic or osteopathic) or dentist with ap-
20 propriate expertise (including, in the case of a child,
21 appropriate pediatric expertise) who was not in-
22 volved in the initial determination.

23 “(d) NOTICE OF DETERMINATION.—

24 “(1) IN GENERAL.—Written notice of a deter-
25 mination made under an internal appeal of a denial

1 of a claim for benefits shall be issued to the partici-
2 pant or beneficiary (or authorized representative)
3 and the treating health care professional as soon as
4 possible in accordance with the medical exigencies of
5 the case and in no case later than 2 days after the
6 date of completion of the review (or, in the case de-
7 scribed in subparagraph (B) or (C) of subsection
8 (b)(3), within the 72-hour or applicable period re-
9 ferred to in such subparagraph).

10 “(2) FINAL DETERMINATION.—The decision by
11 a plan or issuer under this section shall be treated
12 as the final determination of the plan or issuer on
13 a denial of a claim for benefits. The failure of a plan
14 or issuer to issue a determination on an appeal of
15 a denial of a claim for benefits under this section
16 within the applicable timeline established for such a
17 determination shall be treated as a final determina-
18 tion on an appeal of a denial of a claim for benefits
19 for purposes of proceeding to external review under
20 section 503D.

21 “(3) REQUIREMENTS OF NOTICE.—With re-
22 spect to a determination made under this section,
23 the notice described in paragraph (1) shall be pro-
24 vided in printed form and written in a manner cal-

1 culated to be understood by the average participant
2 or beneficiary and shall include—

3 “(A) the specific reasons for the deter-
4 mination (including a summary of the clinical
5 or scientific evidence used in making the deter-
6 mination);

7 “(B) the procedures for obtaining addi-
8 tional information concerning the determina-
9 tion; and

10 “(C) notification of the right to an inde-
11 pendent external review under section 503D
12 and instructions on how to initiate such a re-
13 view.

14 **“SEC. 503D. INDEPENDENT EXTERNAL APPEALS PROCE-**
15 **DURES.**

16 “(a) **RIGHT TO EXTERNAL APPEAL.**—A group health
17 plan, and a health insurance issuer offering health insur-
18 ance coverage in connection with a group health plan, shall
19 provide in accordance with this section participants and
20 beneficiaries (or authorized representatives) with access to
21 an independent external review for any denial of a claim
22 for benefits in any case in which the amount involved ex-
23 ceeds \$100.

24 “(b) **INITIATION OF THE INDEPENDENT EXTERNAL**
25 **REVIEW PROCESS.**—

1 “(1) TIME TO FILE.—A request for an inde-
2 pendent external review under this section shall be
3 filed with the plan or issuer not later than 180 days
4 after the date on which the participant or bene-
5 ficiary receives notice of the denial under section
6 503C(d) or notice of waiver of internal review under
7 section 503C(a)(4) or the date on which the plan or
8 issuer has failed to make a timely decision under
9 section 503C(d)(2).

10 “(2) FILING OF REQUEST.—

11 “(A) IN GENERAL.—Subject to the suc-
12 ceeding provisions of this subsection, a group
13 health plan, and a health insurance issuer offer-
14 ing health insurance coverage, may—

15 “(i) except as provided in subpara-
16 graph (B)(i), require that a request for re-
17 view be in writing;

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

21 “(iii) except if waived by the plan or
22 issuer under section 503C(a)(4), condition
23 access to an independent external review
24 under this section upon a final determina-
25 tion of a denial of a claim for benefits

1 under the internal review procedure under
2 section 503C;

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

7 “(v) require that a request for review
8 include the consent of the participant or
9 beneficiary (or authorized representative)
10 for the release of medical information or
11 records of the participant or beneficiary to
12 the qualified external review entity for the
13 sole purpose of conducting external review
14 activities.

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

17 “(i) ORAL REQUESTS PERMITTED IN
18 EXPEDITED OR CONCURRENT CASES.—In
19 the case of an expedited or concurrent ex-
20 ternal review as provided for under sub-
21 section (e), the request may be made oral-
22 ly. A group health plan, or health insur-
23 ance issuer offering health insurance cov-
24 erage, may require that the participant or
25 beneficiary (or authorized representative)

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

13 “(ii) EXCEPTION TO FILING FEE RE-
14 QUIREMENT.—

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

23 “(II) FEE NOT REQUIRED.—Pay-
24 ment of a filing fee shall not be re-
25 quired under subparagraph (A)(iv) if

1 the plan or issuer waives the internal
2 appeals process under section
3 503C(a)(4).

4 “(III) REFUNDING OF FEE.—
5 The filing fee paid under subpara-
6 graph (A)(iv) shall be refunded if the
7 determination under the independent
8 external review is to reverse the denial
9 which is the subject of the review.

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

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

18 “(1) IN GENERAL.—Upon the filing of a re-
19 quest for independent external review with the group
20 health plan, or health insurance issuer offering
21 health insurance coverage, the plan or issuer shall
22 immediately refer such request, and forward the
23 plan or issuer’s initial decision (including the infor-
24 mation described in section 503C(d)(3)(A)), to a

1 qualified external review entity selected in accord-
2 ance with this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 or issuer, the participant or beneficiary (or
2 authorized representative) filing the re-
3 quest, and the treating health care profes-
4 sional (if any) that the denial is not sub-
5 ject to independent medical review. Such
6 notice—

7 “(I) shall be written (and, in ad-
8 dition, may be provided orally) in a
9 manner calculated to be understood
10 by an average participant or bene-
11 ficiary;

12 “(II) shall include the reasons for
13 the determination;

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

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

20 “(ii) GENERAL TIMELINE FOR DETER-
21 MINATIONS.—Upon receipt of information
22 under paragraph (2), the qualified external
23 review entity, and if required the inde-
24 pendent medical review panel conducting
25 independent medical review under sub-

1 section (d), shall make a determination
2 within the overall timeline that is applica-
3 ble to the case under review as described
4 in subsection (e), except that if the entity
5 determines that a referral to an inde-
6 pendent medical review panel is not re-
7 quired, the entity shall provide notice of
8 such determination to the participant or
9 beneficiary (or authorized representative)
10 within such timeline and within 2 days of
11 the date of such determination.

12 “(d) INDEPENDENT MEDICAL REVIEW.—

13 “(1) IN GENERAL.—If a qualified external re-
14 view entity determines under subsection (c) that a
15 denial of a claim for benefits is eligible for inde-
16 pendent medical review, the entity shall refer the de-
17 nial involved to an independent medical review panel
18 comprised of 3 members meeting the requirements
19 of subsection (g) for the conduct of an independent
20 medical review under this subsection.

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

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

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

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

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

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

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

7 “(B) STANDARD FOR DETERMINATION.—
8 The independent medical review panel’s deter-
9 mination relating to the medical necessity and
10 appropriateness, or the experimental or inves-
11 tigation nature, or the evaluation of the medical
12 facts of the item, service, or condition shall be
13 based on the medical condition of the partici-
14 pant or beneficiary (including the medical
15 records of the participant or beneficiary) and
16 valid, relevant scientific evidence and clinical
17 evidence, including peer-reviewed medical lit-
18 erature or findings and including expert opin-
19 ion.

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

1 services for which benefits are specifically ex-
2 cluded or expressly limited under the plan or
3 coverage in the plain language of the plan docu-
4 ment (and which are disclosed under section
5 121(b)(1)(C)) except to the extent that the ap-
6 plication or interpretation of the exclusion or
7 limitation involves a determination described in
8 paragraph (2).

9 “(D) EVIDENCE AND INFORMATION TO BE
10 USED IN MEDICAL REVIEWS.—In making a de-
11 termination under this subsection, the inde-
12 pendent medical review panel shall also consider
13 appropriate and available evidence and informa-
14 tion, including the following:

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

20 “(ii) The recommendation of the
21 treating health care professional and the
22 evidence, guidelines, and rationale used by
23 the treating health care professional in
24 reaching such recommendation.

1 “(iii) Additional relevant evidence or
2 information obtained by the independent
3 medical review panel or submitted by the
4 plan, issuer, participant or beneficiary (or
5 an authorized representative), or treating
6 health care professional.

7 “(iv) The plan or coverage document.

8 “(E) INDEPENDENT DETERMINATION.—In
9 making determinations under this subtitle, a
10 qualified external review entity and an inde-
11 pendent medical review panel shall—

12 “(i) consider the claim under review
13 without deference to the determinations
14 made by the plan or issuer or the rec-
15 ommendation of the treating health care
16 professional (if any); and

17 “(ii) consider, but not be bound by
18 the definition used by the plan or issuer of
19 ‘medically necessary and appropriate’, or
20 ‘experimental or investigational’, or other
21 substantially equivalent terms that are
22 used by the plan or issuer to describe med-
23 ical necessity and appropriateness or ex-
24 perimental or investigational nature of the
25 treatment.

1 “(F) DETERMINATION OF INDEPENDENT
2 MEDICAL REVIEW PANEL.—An independent
3 medical review panel shall, in accordance with
4 the deadlines described in subsection (e), pre-
5 pare a written determination to uphold or re-
6 verse the denial under review. Such written de-
7 termination shall include—

8 “(i) the determination of the panel;

9 “(ii) the specific reasons of the panel
10 for such determination, including a sum-
11 mary of the clinical or scientific evidence
12 used in making the determination; and

13 “(iii) with respect to a determination
14 to reverse the denial under review, a time-
15 frame within which the plan or issuer must
16 comply with such determination.

17 “(G) NONBINDING NATURE OF ADDI-
18 TIONAL RECOMMENDATIONS.—In addition to
19 the determination under subparagraph (F), the
20 independent medical review panel may provide
21 the plan or issuer and the treating health care
22 professional with additional recommendations in
23 connection with such a determination, but any
24 such recommendations shall not affect (or be

1 treated as part of) the determination and shall
2 not be binding on the plan or issuer.

3 “(e) TIMELINES AND NOTIFICATIONS.—

4 “(1) TIMELINES FOR INDEPENDENT MEDICAL
5 REVIEW.—

6 “(A) PRIOR AUTHORIZATION DETERMINA-
7 TION.—

8 “(i) IN GENERAL.—The independent
9 medical review panel shall make a deter-
10 mination under subsection (d) on a denial
11 of a claim for benefits in accordance with
12 the medical exigencies of the case but not
13 later than 14 days after the date of receipt
14 of information under subsection (c)(2) if
15 the review involves a prior authorization of
16 items or services and in no case later than
17 21 days after the date the request for ex-
18 ternal review is received.

19 “(ii) EXPEDITED DETERMINATION.—
20 Notwithstanding clause (i) and subject to
21 clause (iii), the independent medical review
22 panel shall make an expedited determina-
23 tion under subsection (d) on a denial of a
24 claim for benefits described in clause (i),
25 when a request for such an expedited de-

1 termination is made by a participant or
2 beneficiary (or authorized representative)
3 at any time during the process for making
4 a determination, and a health care profes-
5 sional certifies, with the request, that a de-
6 termination under the timeline described in
7 clause (i) would seriously jeopardize the
8 life or health of the participant or bene-
9 ficiary or the ability of the participant or
10 beneficiary to maintain or regain maximum
11 function. Such determination shall be
12 made as soon as possible based on the
13 medical exigencies of the case involved and
14 in no case later than 72 hours after the
15 time the request for external review is re-
16 ceived by the qualified external review enti-
17 ty.

18 “(iii) ONGOING CARE DETERMINA-
19 TION.—Notwithstanding clause (i), in the
20 case of a review described in such sub-
21 clause that involves a termination or reduc-
22 tion of care, the notice of the determina-
23 tion shall be completed not later than 24
24 hours after the time the request for exter-
25 nal review is received by the qualified ex-

1 ternal review entity and before the end of
2 the approved period of care.

3 “(B) RETROSPECTIVE DETERMINATION.—

4 The independent medical review panel shall
5 complete a review under subsection (d) in the
6 case of a retrospective determination concerting
7 a denial of a claim for benefits not later than
8 30 days after the date of receipt of information
9 under subsection (c)(2) and in no case later
10 than 60 days after the date the request for ex-
11 ternal review is received by the qualified exter-
12 nal review entity.

13 “(2) NOTIFICATION OF DETERMINATION.—The
14 external review entity shall ensure that the plan or
15 issuer, the participant or beneficiary (or authorized
16 representative) and the treating health care profes-
17 sional (if any) receives a copy of the written deter-
18 mination of the independent medical review panel
19 prepared under subsection (d)(3)(F). Nothing in this
20 paragraph shall be construed as preventing an entity
21 or panel from providing an initial oral notice of the
22 determination.

23 “(3) FORM OF NOTICES.—Determinations and
24 notices under this subsection shall be written in a

1 manner calculated to be understood by an average
2 participant.

3 “(f) COMPLIANCE.—

4 “(1) APPLICATION OF DETERMINATIONS.—

5 “(A) EXTERNAL REVIEW DETERMINATIONS
6 BINDING ON PLAN.—The determinations of an
7 external review entity and an independent med-
8 ical review panel under this section shall be
9 binding upon the plan or issuer involved.

10 “(B) COMPLIANCE WITH DETERMINA-
11 TION.—If the determination of an independent
12 medical review panel is to reverse the denial,
13 the plan or issuer, upon the receipt of such de-
14 termination, shall authorize coverage to comply
15 with the panel’s determination in accordance
16 with the timeframe established by the panel.

17 “(2) FAILURE TO COMPLY.—

18 “(A) IN GENERAL.—If a plan or issuer
19 fails to comply with the timeframe established
20 under paragraph (1)(B) with respect to a par-
21 ticipant or beneficiary, where such failure to
22 comply is caused by the plan or issuer, the par-
23 ticipant or beneficiary may obtain the items or
24 services involved (in a manner consistent with
25 the determination of the independent external

1 review entity) from any provider regardless of
2 whether such provider is a participating pro-
3 vider under the plan or coverage.

4 “(B) REIMBURSEMENT.—

5 “(i) IN GENERAL.—Where a partici-
6 pant or beneficiary obtains items or serv-
7 ices in accordance with subparagraph (A),
8 the plan or issuer involved shall provide for
9 reimbursement of the costs of such items
10 or services. Such reimbursement shall be
11 made to the treating health care profes-
12 sional or to the participant or beneficiary
13 (in the case of a participant or beneficiary
14 who pays for the costs of such items or
15 services).

16 “(ii) AMOUNT.—The plan or issuer
17 shall fully reimburse a professional, partici-
18 pant or beneficiary under clause (i) for the
19 total costs of the items or services provided
20 (regardless of any plan limitations that
21 may apply to the coverage of such items or
22 services) so long as the items or services
23 were provided in a manner consistent with
24 the determination of the independent med-
25 ical review panel.

1 “(C) FAILURE TO REIMBURSE.—Where a
2 plan or issuer fails to provide reimbursement to
3 a professional, participant or beneficiary in ac-
4 cordance with this paragraph, the professional,
5 participant or beneficiary may commence a civil
6 action (or utilize other remedies available under
7 law) to recover only the amount of any such re-
8 imbursement that is owed by the plan or issuer
9 and any necessary legal costs or expenses (in-
10 cluding attorney’s fees) incurred in recovering
11 such reimbursement.

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

15 “(3) PENALTIES AGAINST AUTHORIZED OFFI-
16 CIALS FOR REFUSING TO AUTHORIZE THE DETER-
17 MINATION OF AN INDEPENDENT MEDICAL REVIEW
18 PANEL.—

19 “(A) MONETARY PENALTIES.—

20 “(i) IN GENERAL.—In any case in
21 which the determination of an independent
22 medical review panel under this section is
23 not followed by a group health plan, or by
24 a health insurance issuer offering health
25 insurance coverage, any person who, acting

1 in the capacity of authorizing the benefit,
2 causes such refusal may, in the discretion
3 in a court of competent jurisdiction, be lia-
4 ble to an aggrieved participant or bene-
5 ficiary for a civil penalty in an amount of
6 up to \$1,000 a day from the date on which
7 the determination was transmitted to the
8 plan or issuer by the external review entity
9 until the date the refusal to provide the
10 benefit is corrected.

11 “(ii) ADDITIONAL PENALTY FOR FAIL-
12 ING TO FOLLOW TIMELINE.—In any case
13 in which treatment was not commenced by
14 the plan in accordance with the determina-
15 tion of an independent external review en-
16 tity, the Secretary shall assess a civil pen-
17 alty of \$10,000 against the plan and the
18 plan shall pay such penalty to the partici-
19 pant or beneficiary involved.

20 “(B) CEASE AND DESIST ORDER AND
21 ORDER OF ATTORNEY’S FEES.—In any action
22 described in subparagraph (A) brought by a
23 participant or beneficiary with respect to a
24 group health plan, or a health insurance issuer
25 offering health insurance coverage, in which a

1 plaintiff alleges that a person referred to in
2 such subparagraph has taken an action result-
3 ing in a refusal of a benefit determined by an
4 external appeal entity to be covered, or has
5 failed to take an action for which such person
6 is responsible under the terms and conditions of
7 the plan or coverage and which is necessary
8 under the plan or coverage for authorizing a
9 benefit, the court shall cause to be served on
10 the defendant an order requiring the
11 defendant—

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

14 “(ii) to pay to the plaintiff a reason-
15 able attorney’s fee and other reasonable
16 costs relating to the prosecution of the ac-
17 tion on the charges on which the plaintiff
18 prevails.

19 “(C) ADDITIONAL CIVIL PENALTIES.—

20 “(i) IN GENERAL.—In addition to any
21 penalty imposed under subparagraph (A)
22 or (B), the Secretary may assess a civil
23 penalty against a person acting in the ca-
24 pacity of authorizing a benefit determined
25 by an external review entity for one or

1 more group health plans, or health insur-
2 ance issuers offering health insurance cov-
3 erage, for—

4 “(I) any pattern or practice of
5 repeated refusal to authorize a benefit
6 determined by an external appeal enti-
7 ty to be covered; or

8 “(II) any pattern or practice of
9 repeated violations of the require-
10 ments of this section with respect to
11 such plan or coverage.

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

18 “(I) 25 percent of the aggregate
19 value of benefits shown by the Sec-
20 retary to have not been provided, or
21 unlawfully delayed, in violation of this
22 section under such pattern or prac-
23 tice; or

24 “(II) \$500,000.

1 “(4) PROTECTION OF LEGAL RIGHTS.—Nothing
2 in this subsection or subtitle shall be construed as
3 altering or eliminating any cause of action or legal
4 rights or remedies of participants, beneficiaries, and
5 others under State or Federal law (including sec-
6 tions 502 and 503), including the right to file judi-
7 cial actions to enforce rights.

8 “(g) QUALIFICATIONS OF MEMBERS OF INDE-
9 PENDENT MEDICAL REVIEW PANELS.—

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

14 “(A) each member of the panel meets the
15 qualifications described in paragraphs (2) and
16 (3);

17 “(B) with respect to each review the re-
18 quirements described in paragraphs (4) and (5)
19 for the panel are met; and

20 “(C) compensation provided by the entity
21 to each member of the panel is consistent with
22 paragraph (6).

23 “(2) LICENSURE AND EXPERTISE.—Each mem-
24 ber of the independent medical review panel shall be

1 a physician (allopathic or osteopathic) or health care
2 professional who—

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

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

9 “(3) INDEPENDENCE.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), each member of the independent
12 medical review panel in a case shall—

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

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

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

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

23 “(i) prohibit an individual, solely on
24 the basis of affiliation with the plan or

1 issuer, from serving as a member of an
2 independent medical review panel if—

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

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

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

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

18 “(ii) prohibit an individual who has
19 staff privileges at the institution where the
20 treatment involved takes place from serv-
21 ing as a member of an independent med-
22 ical review panel merely on the basis of
23 such affiliation if the affiliation is disclosed
24 to the plan or issuer and the participant or

1 beneficiary (or authorized representative),
2 and neither party objects; or

3 “(iii) prohibit receipt of compensation
4 by a member of an independent medical re-
5 view panel from an entity if the compensa-
6 tion is provided consistent with paragraph
7 (6).

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

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

13 “(i) by a physician, the members of
14 an independent medical review panel shall
15 be practicing physicians (allopathic or os-
16 teopathic) of the same or similar specialty
17 as a physician who typically treats the con-
18 dition, makes the diagnosis, or provides the
19 type of treatment under review; or

20 “(ii) by a health care professional
21 (other than a physician), at least two of
22 the members of an independent medical re-
23 view panel shall be practicing physicians
24 (allopathic or osteopathic) of the same or
25 similar specialty as the health care profes-

1 sional who typically treats the condition,
2 makes the diagnosis, or provides the type
3 of treatment under review, and, if deter-
4 mined appropriate by the qualified external
5 review entity, the third member of such
6 panel shall be a practicing health care pro-
7 fessional (other than such a physician) of
8 such a same or similar specialty.

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

16 “(5) PEDIATRIC EXPERTISE.—In the case of an
17 external review relating to a child, a member of an
18 independent medical review panel shall have exper-
19 tise under paragraph (2) in pediatrics.

20 “(6) LIMITATIONS ON REVIEWER COMPENSA-
21 TION.—Compensation provided by a qualified exter-
22 nal review entity to a member of an independent
23 medical review panel in connection with a review
24 under this section shall—

25 “(A) not exceed a reasonable level; and

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

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

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

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

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

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

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

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

25 “(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

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

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

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

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

15 “(B) STATE AUTHORITY WITH RESPECT
16 TO QUALIFIED EXTERNAL REVIEW ENTITIES
17 FOR HEALTH INSURANCE ISSUERS.—With re-
18 spect to health insurance issuers offering health
19 insurance coverage in a State, the State may
20 provide for external review activities to be con-
21 ducted by a qualified external appeal entity that
22 is designated by the State or that is selected
23 by the State in a manner determined by the
24 State to assure an unbiased determination.

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

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

11 “(A) be consistent with the standards the
12 Secretary shall establish to assure there is no
13 real or apparent conflict of interest in the con-
14 duct of external review activities; and

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

18 Subparagraph (B) shall not be construed as apply-
19 ing to the imposition of a filing fee under subsection
20 (b)(2)(A)(iv) or costs incurred by the participant or
21 beneficiary (or authorized representative) or treating
22 health care professional (if any) in support of the re-
23 view, including the provision of additional evidence
24 or information.

25 “(4) QUALIFICATIONS.—

1 “(A) IN GENERAL.—In this section, the
2 term ‘qualified external review entity’ means, in
3 relation to a plan or issuer, an entity that is
4 initially certified (and periodically recertified)
5 under subparagraph (C) as meeting the fol-
6 lowing requirements:

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

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

22 “(iii) The entity has provided assur-
23 ances that it will conduct external review
24 activities consistent with the applicable re-
25 quirements of this section and standards

1 specified in subparagraph (C), including
2 that it will not conduct any external review
3 activities in a case unless the independence
4 requirements of subparagraph (B) are met
5 with respect to the case.

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

9 “(v) The entity meets such other re-
10 quirements as the Secretary provides by
11 regulation.

12 “(B) INDEPENDENCE REQUIREMENTS.—

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

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

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

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

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

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

14 “(I) not exceed a reasonable
15 level; and

16 “(II) not be contingent on any
17 decision rendered by the entity or by
18 any independent medical review panel.

19 “(C) CERTIFICATION AND RECERTIFI-
20 CATION PROCESS.—

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

1 “(I) under a process that is rec-
2 ognized or approved by the Secretary;
3 or

4 “(II) by a qualified private
5 standard-setting organization that is
6 approved by the Secretary under
7 clause (iii).

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

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

21 “(I) will carry out (and has car-
22 ried out, in the case of recertification)
23 the responsibilities of such an entity
24 in accordance with this section, in-
25 cluding meeting applicable deadlines;

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

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

11 “(IV) in the case recertification,
12 shall review the matters described in
13 clause (iv).

14 “(iii) APPROVAL OF QUALIFIED PRI-
15 VATE STANDARD-SETTING ORGANIZA-
16 TIONS.—For purposes of clause (i)(II), the
17 Secretary may approve a qualified private
18 standard-setting organization if such Sec-
19 retary finds that the organization only cer-
20 tifies (or recertifies) external review enti-
21 ties that meet at least the standards re-
22 quired for the certification (or recertifi-
23 cation) of external review entities under
24 clause (ii).

1 “(iv) CONSIDERATIONS IN RECERTIFI-
2 CATIONS.—In conducting recertifications of
3 a qualified external review entity under
4 this paragraph, the Secretary or organiza-
5 tion conducting the recertification shall re-
6 view compliance of the entity with the re-
7 quirements for conducting external review
8 activities under this section, including the
9 following:

10 “(I) Provision of information
11 under subparagraph (D).

12 “(II) Adherence to applicable
13 deadlines (both by the entity and by
14 independent medical review panels it
15 refers cases to).

16 “(III) Compliance with limita-
17 tions on compensation (with respect to
18 both the entity and independent med-
19 ical review panels it refers cases to).

20 “(IV) Compliance with applicable
21 independence requirements.

22 “(v) PERIOD OF CERTIFICATION OR
23 RECERTIFICATION.—A certification or re-
24 certification provided under this paragraph

1 shall extend for a period not to exceed 2
2 years.

3 “(vi) REVOCATION.—A certification or
4 recertification under this paragraph may
5 be revoked by the Secretary or by the or-
6 ganization providing such certification
7 upon a showing of cause.

8 “(D) PROVISION OF INFORMATION.—

9 “(i) IN GENERAL.—A qualified exter-
10 nal review entity shall provide to the Sec-
11 retary (or the State in the case of external
12 review activities provided for by a State
13 pursuant to paragraph (1)(B)), in such
14 manner and at such times as such Sec-
15 retary (or State) may require, such infor-
16 mation (relating to the denials which have
17 been referred to the entity for the conduct
18 of external review under this section) as
19 such Secretary (or State) determines ap-
20 propriate to assure compliance with the
21 independence and other requirements of
22 this section to monitor and assess the qual-
23 ity of its external review activities and lack
24 of bias in making determinations. Such in-
25 formation shall include information de-

1 scribed in clause (ii) but shall not include
2 individually identifiable medical informa-
3 tion.

4 “(ii) INFORMATION TO BE IN-
5 CLUDED.—The information described in
6 this subclause with respect to an entity is
7 as follows:

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

11 “(II) The disposition by the enti-
12 ty of such denials, including the num-
13 ber referred to an independent med-
14 ical review panel and the reasons for
15 such dispositions (including the appli-
16 cation of exclusions), on a plan or
17 issuer-specific basis and on a health
18 care specialty-specific basis.

19 “(III) The length of time in mak-
20 ing determinations with respect to
21 such denials.

22 “(IV) Updated information on
23 the information required to be sub-
24 mitted as a condition of certification

1 with respect to the entity’s perform-
2 ance of external review activities.

3 “(iii) INFORMATION TO BE PROVIDED
4 TO CERTIFYING ORGANIZATION.—

5 “(I) IN GENERAL.—In the case
6 of a qualified external review entity
7 which is certified (or recertified)
8 under this subsection by a qualified
9 private standard-setting organization,
10 at the request of the organization, the
11 entity shall provide the organization
12 with the information provided to the
13 Secretary under clause (i).

14 “(II) ADDITIONAL INFORMA-
15 TION.—Nothing in this subparagraph
16 shall be construed as preventing such
17 an organization from requiring addi-
18 tional information as a condition of
19 certification or recertification of an
20 entity.

21 “(iv) USE OF INFORMATION.—Infor-
22 mation provided under this subparagraph
23 may be used by the Secretary and qualified
24 private standard-setting organizations to
25 conduct oversight of qualified external re-

1 view entities, including recertification of
2 such entities, and shall be made available
3 to the public in an appropriate manner.

4 “(E) LIMITATION ON LIABILITY.—No
5 qualified external review entity having a con-
6 tract with a plan or issuer, and no person who
7 is employed by any such entity or who furnishes
8 professional services to such entity (including as
9 a member of an independent medical review
10 panel), shall be held by reason of the perform-
11 ance of any duty, function, or activity required
12 or authorized pursuant to this section, to be
13 civilly liable under any law of the United States
14 or of any State (or political subdivision thereof)
15 if there was no actual malice or gross mis-
16 conduct in the performance of such duty, func-
17 tion, or activity.”.

18 (b) CONFORMING AMENDMENT.—The table of con-
19 tents in section 1 of the Employee Retirement Income Se-
20 curity Act of 1974 is amended by inserting after the item
21 relating to section 503 the following:

“Sec. 503A. Utilization review activities.

“Sec. 503B. Procedures for initial claims for benefits and prior authorization determinations.

“Sec. 503C. Internal appeals of claims denials.

“Sec. 503D. Independent external appeals procedures.”.

1 **SEC. 122. CONFORMING AMENDMENTS TO PUBLIC HEALTH**
2 **SERVICE ACT.**

3 (a) GROUP HEALTH PLANS.—Title XXVII of the
4 Public Health Service Act, as amended by sections 102(a)
5 and 112(a), is amended by inserting after section 2708
6 the following new section:

7 **“SEC. 2709. STANDARD RELATING TO ACCOUNTABILITY.**

8 “Subject to section 2724(c), a group health plan, and
9 health insurance coverage offered in connection with a
10 group health plan, shall comply with the requirements of
11 sections 503A through 503D of the Employee Retirement
12 Income Security Act of 1974 (as in effect as of the day
13 after the date of the enactment of such Act) and such re-
14 quirements shall be deemed to be incorporated into this
15 section. For purposes of this section, references in such
16 sections 503A through 503D to the Secretary shall be
17 deemed references to the Secretary of Health and Human
18 Services.”.

19 (b) INDIVIDUAL HEALTH PLANS.—Title XXVII of
20 the Public Health Service Act, as amended by sections
21 102(b) and 112(b), is amended by inserting after section
22 2754 the following new section:

23 **“SEC. 2755. STANDARD RELATING TO ACCOUNTABILITY.**

24 “Subject to section 2762A(c), the provisions of sec-
25 tions 503A through 503D of the Employee Retirement In-
26 come Security Act of 1974 (as in effect as of the day after

1 the date of the enactment of such Act) shall apply to
2 health insurance coverage offered by a health insurance
3 issuer in the individual market for an enrollee in the same
4 manner as they apply to health insurance coverage offered
5 by a health insurance issuer for a participant or bene-
6 ficiary in connection with a group health plan in the small
7 or large group market and the requirements referred to
8 in such section shall be deemed to be incorporated into
9 this section. For purposes of this section, references in
10 such sections 503A through 503D to the Secretary shall
11 be deemed references to the Secretary of Health and
12 Human Services.”.

13 **SEC. 123. CONFORMING AMENDMENTS TO THE INTERNAL**
14 **REVENUE CODE OF 1986.**

15 Subchapter B of chapter 100 of the Internal Revenue
16 Code of 1986, as amended by sections 103 and 113, is
17 amended—

18 (1) in the table of sections, by inserting after
19 the item relating to section 9814 the following new
20 item:

“Sec. 9815. Standard relating to plan accountability.”;

21 and

22 (2) by inserting after section 9814 the fol-
23 lowing:

1 **“SEC. 9815. STANDARD RELATING TO PLAN ACCOUNT-**
2 **ABILITY.**

3 “A group health plan shall comply with the require-
4 ments of sections 503A through 503D of the Employee
5 Retirement Income Security Act of 1974 (as in effect as
6 of the day after the date of the enactment of such Act)
7 and such requirements shall be deemed to be incorporated
8 into this section. For purposes of this section, references
9 in such sections 503A through 503D to the Secretary shall
10 be deemed references to the Secretary of the Treasury.”.

11 **Subtitle D—State Flexibility in Ap-**
12 **plying Requirements to Health**
13 **Insurance Issuers**

14 **SEC. 141. STATE FLEXIBILITY IN APPLYING REQUIRE-**
15 **MENTS TO HEALTH INSURANCE ISSUERS**
16 **UNDER ERISA; PLAN SATISFACTION OF CER-**
17 **TAIN REQUIREMENTS.**

18 (a) IN GENERAL.—Section 731(a) of the Employee
19 Retirement Income Security Act of 1974 is amended—

20 (1) in section 731(a)(1) (29 U.S.C. 1191(a)),
21 by inserting “and section 731A” after “Subject to
22 paragraph (2)”; and

23 (2) by inserting after section 731 the following
24 new section:

1 **“SEC. 731A. STATE FLEXIBILITY IN APPLYING PATIENTS’**
2 **BILL OF RIGHTS AND PATIENT ACCESS TO IN-**
3 **FORMATION REQUIREMENTS; PLAN SATIS-**
4 **FACTION OF CERTAIN REQUIREMENTS.**

5 “(a) STATE FLEXIBILITY.—The requirements of a
6 section of subpart C (relating to patients’ bill of rights)
7 and of section 714 (relating to patient access to informa-
8 tion) shall not apply with respect to health insurance cov-
9 erage (and to a group health plan insofar as it provides
10 benefits in the form of health insurance coverage) in a
11 State—

12 “(1) before January 1, 2003; and

13 “(2) on or after such date, during any period
14 for which the State certifies to the Patients’ Protec-
15 tion Certification Board (established under sub-
16 section (c)) that the State has in effect a State law
17 (as defined in section 2723(d)(1) of the Public
18 Health Service Act) that—

19 “(A) addresses the patient protections or
20 access to information in such section; and

21 “(B)(i) adopts the Federal standard
22 under such section with respect to the re-
23 quirements; or

24 “(ii) is consistent with the purposes of
25 the section and the Board has not found

1 such certification invalid under subsection
2 (b)(2)(A).

3 “(b) PATIENTS’ PROTECTION CERTIFICATION
4 BOARD; CERTIFICATION REVIEW PROCESS.—

5 “(1) ESTABLISHMENT OF BOARD.—

6 “(A) IN GENERAL.—There is hereby estab-
7 lished in the Health Resources and Services Ad-
8 ministration of the Department of Health and
9 Human Services a Patients’ Protection Certifi-
10 cation Board (in this section referred to as the
11 ‘Board’).

12 “(B) COMPOSITION.—The Board shall be
13 composed of 13 members appointed by the
14 President, by and with the advice and consent
15 of the Senate, from among individuals who rep-
16 resent consumers and employers or have exper-
17 tise in law, medicine, insurance, employee bene-
18 fits, and related fields. Members shall first be
19 appointed to the Board not earlier than Feb-
20 ruary 1, 2001, and no later than May 1, 2001.

21 “(C) TERMS.—The terms of members of
22 the Board shall be for 3 years except that for
23 the members first appointed the President shall
24 designate staggered terms of 3 years for 2
25 members, 2 years for 2 members, and 1 year

1 for one member. A vacancy in the Board shall
2 be filled in the same manner in which the origi-
3 nal appointment was made and a member ap-
4 pointed to fill a vacancy occurring before the
5 expiration of the term for which the member's
6 predecessor was appointed shall be appointed
7 only for the remainder of that term.

8 “(D) COMPENSATION.—To the extent pro-
9 vided in advance in appropriations Acts, while
10 serving on the business of the Board (including
11 travel time), each member of the Board—

12 “(i) shall be entitled to receive com-
13 pensation at the daily equivalent of the an-
14 nual rate of basic pay provided for level IV
15 of the Executive Schedule under section
16 5315 of title 5, United States Code for
17 each day (including travel time) during
18 which the member is engaged in the actual
19 performance of duties as such a member;
20 and

21 “(ii) while so serving away from home
22 and the member's regular place of busi-
23 ness, may be allowed travel expenses, as
24 authorized by the Board.

25 “(2) DUTIES.—

1 “(A) REVIEW OF CERTIFICATIONS SUB-
2 MITTED.—

3 “(i) IN GENERAL.—The Board shall
4 review certifications submitted under sub-
5 section (a)(2).

6 “(ii) DEFERENCE TO STATES.—Such
7 a certification submitted for a State law
8 with respect to the requirements of a sec-
9 tion is deemed valid unless, within 90 days
10 after the date of its submittal to the
11 Board, the Board finds that there is clear
12 and convincing evidence of substantial non-
13 compliance of the State law with the re-
14 quirements of such section.

15 “(B) ANNUAL CONGRESSIONAL RE-
16 PORTS.—The Board shall submit to Congress
17 an annual report on its activities. The first an-
18 nual report shall focus specifically on the devel-
19 opment by the Board of criteria for the evalua-
20 tion of State laws and any other activities of
21 the Board during its first year of operation.

22 “(3) ORGANIZATION.—

23 “(A) CHAIR.—The Board shall elect a
24 member of the Board to serve as chair.

1 “(B) MEETINGS.—The Board shall meet
2 at least quarterly and otherwise at the call of
3 the chair or upon the written request of a ma-
4 jority of its members.

5 “(C) QUORUM.—Seven members of the
6 Board shall constitute a quorum thereof, but a
7 lesser number may hold hearings and take testi-
8 mony.

9 “(4) DIRECTOR AND STAFF; EXPERTS AND
10 CONSULTANTS.—To the extent provided in advance
11 in appropriations Acts, the Board may—

12 “(A) employ and fix the compensation of
13 an Executive Director and such other personnel
14 as may be necessary to carry out the Board’s
15 duties, without regard to the provisions of title
16 5, United States Code, governing appointments
17 in the competitive service;

18 “(B) procure temporary and intermittent
19 services under section 3109(b) of title 5, United
20 States Code; and

21 “(C) provide transportation and subsist-
22 ence for persons serving the Board without
23 compensation.

24 “(5) POWERS.—

25 “(A) OBTAINING OFFICIAL DATA.—

1 “(i) IN GENERAL.—The Board may
2 secure directly from any department or
3 agency of the United States information
4 necessary to enable it to carry out its du-
5 ties.

6 “(ii) REQUEST OF CHAIR.—Upon re-
7 quest of the chair, the head of that depart-
8 ment or agency shall furnish that informa-
9 tion to the Board on an agreed upon
10 schedule.

11 “(B) AGENCY ASSISTANCE.—The Board
12 may seek such assistance and support as may
13 be required in the performance of its duties
14 from the Secretary of Health and Human Serv-
15 ices, acting through the Health Resources and
16 Services Administration. Any employee of such
17 Administration may be detailed to the Board to
18 assist the Board in carrying out its duties.

19 “(C) CONTRACT AUTHORITY.—To the ex-
20 tent provided in advance in appropriations Act,
21 the Board may enter into contracts or make
22 other arrangements for facilities and services as
23 may be necessary for the conduct of the work
24 of the Board (without regard to section 3709 of
25 the Revised Statutes (41 U.S.C. 5)).

1 “(D) HEARINGS.—The Board may, for the
2 purpose of carrying out its duties, hold hear-
3 ings, sit and act at times and places, take testi-
4 mony, and receive evidence as the Board con-
5 siders appropriate. The Board may administer
6 oaths or affirmations to witnesses appearing be-
7 fore it. To the extent provided in advance in
8 appropriation Acts, the Board may pay reason-
9 able travel expenses to witnesses for travel inci-
10 dent to hearings held by the Board. Nothing in
11 this subsection shall be construed as author-
12 izing the issuance of subpoenas in support of
13 its duties.

14 “(E) RULES.—The Board may prescribe
15 such rules and regulations as it deems nec-
16 essary to carry out this subsection.

17 “(6) AUTHORIZATION OF APPROPRIATIONS.—
18 There are authorized to be appropriated to carry out
19 this subsection—

20 “(A) for fiscal year 2001, \$500,000,

21 “(B) for fiscal year 2002, \$1,000,000, and

22 “(C) for subsequent fiscal years, such
23 sums as may be necessary.

24 “(c) RELATIONSHIP TO GROUP HEALTH PLAN RE-
25 QUIREMENTS.—Nothing in this section shall be construed

1 to affect or modify the provisions of section 514 with re-
2 spect to group health plans (insofar as it provides benefits
3 other than in the form of health insurance coverage).

4 “(d) PLAN SATISFACTION OF CERTAIN REQUIRE-
5 MENTS.—

6 “(1) SATISFACTION OF CERTAIN REQUIRE-
7 MENTS THROUGH INSURANCE.—For purposes of this
8 part, insofar as a group health plan provides bene-
9 fits in the form of health insurance coverage through
10 a health insurance issuer and, under the arrange-
11 ment to offer such coverage, the issuer is legally re-
12 sponsible for compliance with any of the following
13 requirements of this subpart (or of section 714), the
14 plan shall be treated as meeting such requirements
15 and not be considered as failing to meet such re-
16 quirements because of a failure of the issuer to meet
17 such requirements so long as the plan sponsor or its
18 representatives did not cause such failure by the
19 issuer:

20 “(A) Section 721 (relating to access to
21 emergency care).

22 “(B) Section 722 (relating to offering of
23 choice of coverage options).

24 “(C) Section 723 (relating to access to ob-
25 stetric and gynecological care).

1 “(D) Section 724 (relating to access to pe-
2 diatric care).

3 “(E) Section 725 (relating to access to
4 specialty care).

5 “(F) Section 726(a)(1) (relating to con-
6 tinuity in case of termination of provider con-
7 tract) and section 726(a)(2) (relating to con-
8 tinuity in case of termination of issuer con-
9 tract), but only insofar as a replacement issuer
10 assumes the obligation for continuity of care.

11 “(G) Section 728 (relating to access to
12 needed prescription drugs).

13 “(H) Section 730 (relating to coverage for
14 individuals participating in approved clinical
15 trials.)

16 “(I) Section 730C (relating to payment of
17 claims).

18 “(J) Section 714 (relating to access to in-
19 formation).

20 “(2) APPLICATION TO PROHIBITIONS.—If a
21 health insurance issuer offers health insurance cov-
22 erage in connection with a group health plan and
23 takes an action in violation of any of the following
24 sections, the group health plan shall not be liable for
25 such violation unless the plan caused such violation:

1 “(A) Section 727 (relating to prohibition of
2 interference with certain medical communica-
3 tions).

4 “(B) Section 729 (relating to self-payment
5 for behavioral health).

6 “(C) Section 730A (relating to prohibition
7 of discrimination against providers based on li-
8 censure).

9 “(D) Section 730B (relating to prohibition
10 against improper incentive arrangements).

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

15 “(e) CONFORMING REGULATIONS.—The Secretary
16 may issue regulations to coordinate the requirements on
17 group health plans under subpart C, section 714, and sec-
18 tions 503A through 503D with the requirements imposed
19 under the other provisions of this title.”.

20 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
21 REQUIREMENT.—Section 503 of such Act (29 U.S.C.
22 1133) is amended by inserting “(a)” after “SEC. 503.”
23 and by adding at the end the following new subsection:

24 “(b) In the case of a group health plan (as defined
25 in section 733) compliance with the requirements of sec-

1 tions 503A through 503D in the case of a claims denial
 2 shall be deemed compliance with subsection (a) with re-
 3 spect to such claims denial.”.

4 (c) CLERICAL AMENDMENT.—The table of contents
 5 in section 1 of such Act (29 U.S.C. 1001) is amended by
 6 inserting after the item relating to section 731, the fol-
 7 lowing:

“Sec. 731A. State flexibility in applying patients’ bill of rights and patient ac-
 cess to information requirements; plan satisfaction of certain
 requirements.”.

8 **SEC. 142. STATE FLEXIBILITY IN APPLYING REQUIRE-**
 9 **MENTS UNDER THE PUBLIC HEALTH SERV-**
 10 **ICE ACT.**

11 (a) GROUP HEALTH PLANS AND GROUP HEALTH IN-
 12 SURANCE COVERAGE.—Title XXVII of the Public Health
 13 Service Act is amended—

14 (1) in section 2723(a)(1) (42 U.S.C. 300gg–
 15 23(a)(1)), by inserting “and section 2724” after
 16 “Subject to paragraph (2)”; and

17 (2) by inserting after section 2723 the following
 18 new section:

19 **“SEC. 2724. STATE FLEXIBILITY IN APPLYING PATIENTS’**
 20 **BILL OF RIGHTS, PATIENT ACCESS TO INFOR-**
 21 **MATION, AND ACCOUNTABILITY REQUIRE-**
 22 **MENTS.**

23 “(a) IN GENERAL.—The provisions of section 731A
 24 of the Employee Retirement Income Security Act of 1974,

1 apply to the requirements of section 2707 (relating to pa-
2 tients' bill of rights), section 2708 (relating to access to
3 information), and (only with respect to group health plans
4 as applied under section 2721(b)) section 2709 (relating
5 to accountability) in the same manner as such provisions
6 apply to comparable requirements with respect to health
7 insurance coverage provided in connection with a group
8 health plan.

9 “(b) RELATIONSHIP TO GROUP HEALTH PLAN RE-
10 QUIREMENTS.—Nothing in this section shall be construed
11 to affect or modify the provisions of section 514 of the
12 Employee Retirement Income Security Act of 1974 with
13 respect to group health plans (insofar as it provides bene-
14 fits other than in the form of health insurance coverage).”.

15 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
16 Title XXVII of the Public Health Service Act is
17 amended—

18 (1) in section 2762(a) (42 U.S.C. 300gg-
19 62(a)(1)), by inserting “and section 2762A” after
20 “Subject to subsection (b)”; and

21 (2) by inserting after section 2762 the following
22 new section:

1 **“SEC. 2762A. STATE FLEXIBILITY IN APPLYING PATIENTS’**
2 **BILL OF RIGHTS, PATIENT ACCESS TO INFOR-**
3 **MATION, AND ACCOUNTABILITY REQUIRE-**
4 **MENTS.**

5 “The provisions of section 2724 apply in relation to
6 the requirements of section 2753 (relating to patients’ bill
7 of rights), section 2754 (relating to access to information),
8 and section 2755 (relating to accountability) with respect
9 to individual health insurance coverage in the same man-
10 ner as those provisions apply in relation to the require-
11 ments of sections 2707, 2708, and 2709, respectively, as
12 applied to group health plans under section 2721(b).”.

13 **Subtitle E—Effective Dates; Coordi-**
14 **nation in Implementation; Mis-**
15 **cellaneous Provisions**

16 **SEC. 151. EFFECTIVE DATES.**

17 (a) **GROUP HEALTH COVERAGE.—**

18 (1) **IN GENERAL.—**Subject to paragraph (2)
19 and subsection (d), the amendments made by sec-
20 tions 101, 102(a), 103, 111, 112(a), 113, 121,
21 122(a), and 123 shall apply with respect to group
22 health plans, and health insurance coverage offered
23 in connection with group health plans, for plan years
24 beginning on or after January 1, 2002 (in this sec-
25 tion referred to as the “general effective date”) and

1 also shall apply to portions of plan years occurring
2 on and after such date.

3 (2) TREATMENT OF COLLECTIVE BARGAINING
4 AGREEMENTS.—In the case of a group health plan
5 maintained pursuant to one or more collective bar-
6 gaining agreements between employee representa-
7 tives and one or more employers ratified before the
8 date of the enactment of this Act, the amendments
9 made by the provisions referred to in paragraph (1)
10 shall not apply to plan years beginning before the
11 later of—

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

17 (B) the general effective date.

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

24 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
25 Subject to subsection (d), the amendments made by sec-

1 tion 102(b), 112(b), and 122(b) shall apply with respect
2 to individual health insurance coverage offered, sold,
3 issued, renewed, in effect, or operated in the individual
4 market on or after the general effective date.

5 (c) TREATMENT OF RELIGIOUS NONMEDICAL PRO-
6 VIDERS.—

7 (1) IN GENERAL.—Nothing in this Act (or the
8 amendments made thereby) shall be construed to—

9 (A) restrict or limit the right of group
10 health plans, and of health insurance issuers of-
11 fering health insurance coverage, to include as
12 providers religious nonmedical providers;

13 (B) require such plans or issuers to—

14 (i) utilize medically based eligibility
15 standards or criteria in deciding provider
16 status of religious nonmedical providers;

17 (ii) use medical professionals or cri-
18 teria to decide patient access to religious
19 nonmedical providers;

20 (iii) utilize medical professionals or
21 criteria in making decisions in internal or
22 external appeals regarding coverage for
23 care by religious nonmedical providers; or

24 (iv) compel a participant or bene-
25 ficiary to undergo a medical examination

1 or test as a condition of receiving health
2 insurance coverage for treatment by a reli-
3 gious nonmedical provider; or

4 (C) require such plans or issuers to ex-
5 clude religious nonmedical providers because
6 they do not provide medical or other required
7 data, if such data is inconsistent with the reli-
8 gious nonmedical treatment or nursing care
9 provided by the provider.

10 (2) RELIGIOUS NONMEDICAL PROVIDER.—For
11 purposes of this subsection, the term “religious non-
12 medical provider” means a provider who provides no
13 medical care but who provides only religious non-
14 medical treatment or religious nonmedical nursing
15 care.

16 (d) TRANSITION FOR NOTICE REQUIREMENT.—The
17 disclosure of information required under the amendments
18 made by subtitle B of this title shall first be provided pur-
19 suant to—

20 (1) subsection (a) with respect to a group
21 health plan that is maintained as of the general ef-
22 fective date, not later than 30 days before the begin-
23 ning of the first plan year to which the amendments
24 made by such subtitle apply in connection with the
25 plan under such subsection; or

1 (2) subsection (b) with respect to an individual
2 health insurance coverage that is in effect as of the
3 general effective date, not later than 30 days before
4 the first date as of which the amendments made by
5 such subtitle apply to the coverage under such sub-
6 section.

7 (e) CONSTRUCTION.—In applying section 731(a) of
8 the Employee Retirement Income Security Act of 1974
9 and sections 2723(a) and 2762 of the Public Health Serv-
10 ice Act, a State law that provides for equal access to, and
11 availability of, all categories of licensed health care pro-
12 viders and services shall not be treated as preventing the
13 application of any requirement of either such Act.

14 (f) COVERAGE OF LIMITED SCOPE PLANS.—Section
15 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C.
16 300gg-91(c)(2)(A)) and section 733(c)(2)(A) of the Em-
17 ployee Retirement Income Security Act of 1974 (29
18 U.S.C. 1186(c)(2)(A)) shall be deemed not to apply for
19 purposes of applying the requirements imposed by the
20 amendments made by this title.

21 **SEC. 152. REGULATIONS; COORDINATION.**

22 (a) AUTHORITY.—The Secretaries of Health and
23 Human Services, Labor, and the Treasury shall issue such
24 regulations as may be necessary or appropriate to carry

1 out the amendments made by this title before the effective
2 date thereof.

3 (b) COORDINATION IN IMPLEMENTATION.—The Sec-
4 retary of Labor, the Secretary of Health and Human Serv-
5 ices, and the Secretary of the Treasury shall ensure,
6 through the execution of an interagency memorandum of
7 understanding among such Secretaries, that—

8 (1) regulations, rulings, and interpretations
9 issued by such Secretaries relating to the same mat-
10 ter over which such Secretaries have responsibility
11 under the amendments made by this title are admin-
12 istered so as to have the same effect at all times;
13 and

14 (2) coordination of policies relating to enforcing
15 the same requirements through such Secretaries in
16 order to have a coordinated enforcement strategy
17 that avoids duplication of enforcement efforts and
18 assigns priorities in enforcement.

19 (c) USE OF INTERIM FINAL RULES.—Such Secre-
20 taries may promulgate any interim final rules as the Sec-
21 retaries determine are appropriate to carry out this title.

22 (d) LIMITATION ON ENFORCEMENT ACTIONS.—No
23 enforcement action shall be taken, pursuant to the amend-
24 ments made by this title, against a group health plan or
25 health insurance issuer with respect to a violation of a re-

1 requirement imposed by such amendments before the date
2 of issuance of regulations issued in connection with such
3 requirement, if the plan or issuer has sought to comply
4 in good faith with such requirement.

5 **SEC. 153. NO BENEFIT REQUIREMENTS.**

6 Nothing in the amendments made by this title shall
7 be construed to require a group health plan or a health
8 insurance issuer offering health insurance coverage to in-
9 clude specific items and services under the terms of such
10 a plan or coverage, other than those provided under the
11 terms and conditions of such plan or coverage.

12 **SEC. 154. SEVERABILITY.**

13 If any provision of this title, an amendment made by
14 this title, or the application of such provision or amend-
15 ment to any person or circumstance is held to be unconsti-
16 tutional, the remainder of this title, the amendments made
17 by this title, and the application of the provisions of such
18 to any person or circumstance shall not be affected there-
19 by.

20 **TITLE II—REMEDIES**

21 **SEC. 201. AVAILABILITY OF COURT REMEDIES.**

22 (a) CAUSE OF ACTION RELATING TO MEDICALLY RE-
23 VIEWABLE DETERMINATIONS AND TIMELY REVIEW OF
24 CLAIMS.—Section 502 of the Employee Retirement In-

1 come Security Act of 1974 (29 U.S.C. 1132) is
2 amended—

3 (1) in subsection (a)(1), by striking “or” at the
4 end of subparagraph (A), by striking “plan;” in sub-
5 paragraph (B) and inserting “plan, or”, and by add-
6 ing after subparagraph (B) the following new sub-
7 paragraph:

8 “(C) in the case of a group health plan, for
9 the relief provided for in subsection (n) of this
10 section;”; and

11 (2) by adding at the end the following:

12 “(n) CAUSE OF ACTION RELATING TO MEDICALLY
13 REVIEWABLE DETERMINATIONS AND TIMELY REVIEW OF
14 CLAIMS.—

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

16 “(A) a person who is a designated health
17 care decision-maker of a group health plan
18 breaches the covenant of good faith and fair
19 dealing in—

20 “(i) making a medically reviewable de-
21 termination regarding a benefit for items
22 or services under the plan, or

23 “(ii) failing to ensure that—

24 “(I) any denial of claim for bene-
25 fits, or

1 “(II) any decision by the plan on
2 a request, made by a participant or
3 beneficiary under section 503C or
4 503D, for a reversal of an earlier de-
5 cision of the plan,
6 is made and issued to the participant or
7 beneficiary (in such form and manner as
8 may be prescribed in regulations of the
9 Secretary) before the end of the applicable
10 period specified in section 503B, 503C, or
11 503D, and

12 “(B) such breach is the proximate cause of
13 substantial harm to, or wrongful death of, the
14 participant or beneficiary,
15 such person shall be liable to the participant or ben-
16 eficiary (or the estate of such participant or bene-
17 ficiary) for economic and noneconomic damages in
18 connection with such breach and such substantial
19 harm or death (subject to paragraphs (5) and (6)).

20 “(2) DESIGNATED HEALTH CARE DECISION-
21 MAKER.—

22 “(A) IN GENERAL.—A group health plan
23 shall name a designated health care decision-
24 maker for purposes of paragraph (1) with re-

1 spect to any benefits that are not provided
2 through group health insurance coverage.

3 “(B) DEFINITION.—For purposes of this
4 subsection, the term ‘designated health care de-
5 cision-maker’ means a person who—

6 “(i) is named in the plan as the des-
7 ignated health care decision-maker,

8 “(ii) agrees in writing to accept ap-
9 pointment as a designated health care deci-
10 sion-maker,

11 “(iii) is any of the following:

12 “(I) the plan sponsor,

13 “(II) a health insurance issuer,

14 or

15 “(III) any other person who can
16 satisfy requirements set forth in regu-
17 lations promulgated by the Secretary,
18 including the abilities specified in sub-
19 paragraph (C), and

20 “(iv) is not the treating physician or
21 other health care professional in the case
22 involved.

23 “(C) ABILITIES.—The abilities specified in
24 this subparagraph are the abilities to—

1 “(i) carry out the responsibilities set
2 forth in the plan,

3 “(ii) carry out the applicable require-
4 ments of this subsection, and

5 “(iii) meet other applicable require-
6 ments, including any financial obligation
7 for liability under this subsection.

8 “(D) GROUP HEALTH INSURANCE COV-
9 ERAGE.—With respect to benefits provided
10 through group health insurance coverage, the
11 health insurance issuer providing the group
12 health insurance coverage shall be deemed the
13 designated health care decision-maker of the
14 plan.

15 “(E) ABSENCE OF NAMED DESIGNATED
16 HEALTH CARE DECISION-MAKER.—In any case
17 in which a designated health care decision-
18 maker is not named in the plan with respect to
19 benefits that are not provided through group
20 health insurance coverage, the plan sponsor
21 shall be treated as the designated health care
22 decision-maker for purposes of liability under
23 this section with respect to such benefits.

24 “(3) DEFINITIONS.—For purposes of this
25 section—

1 “(A) MEDICALLY REVIEWABLE DETER-
2 MINATION.—The term ‘medically reviewable de-
3 termination’ means a determination described
4 in section 503D(d)(2).

5 “(B) SUBSTANTIAL HARM.—The term
6 ‘substantial harm’ means loss of life, loss or
7 significant impairment of limb, bodily, or men-
8 tal function, significant disfigurement, or severe
9 and chronic pain.

10 “(C) CLAIM FOR BENEFITS; DENIAL.—The
11 terms ‘claim for benefits’ and ‘denial of a claim
12 for benefits’, in connection with a group health
13 plan or health insurance coverage, have the
14 meanings provided such terms in section
15 503B(e).

16 “(D) TERMS AND CONDITIONS.—The term
17 ‘terms and conditions’ includes, with respect to
18 a group health plan or health insurance cov-
19 erage, requirements imposed under section 714
20 and subpart C of part 7.

21 “(E) GROUP HEALTH PLAN AND OTHER
22 RELATED TERMS.—The provisions of sections
23 732(d) and 733 apply for purposes of this sub-
24 section in the same manner as they apply for
25 purposes of part 7, except that the term ‘group

1 health plan’ includes a group health plan (as
2 defined in section 607(1)).

3 “(F) ECONOMIC AND NONECONOMIC DAM-
4 AGES.—The terms ‘economic damages’ and
5 ‘noneconomic damages’ do not include punitive
6 damages.

7 “(4) REQUIREMENT OF EXHAUSTION OF AD-
8 MINISTRATIVE REMEDIES.—

9 “(A) IN GENERAL.—In the case of a cause
10 of action described in paragraph (1)(A)(i),
11 paragraph (1) applies only if all remedies under
12 sections 503C and 503D with respect to such
13 cause of action have been exhausted.

14 “(B) EXTERNAL REVIEW REQUIRED
15 WHERE AVAILABLE.—For purposes of subpara-
16 graph (A), all remedies described in subpara-
17 graph (A) shall be deemed not to be exhausted
18 until such remedies under section 503D (to the
19 extent they are available) have been elected and
20 are exhausted by issuance of a final determina-
21 tion by a qualified external review entity or an
22 independent medical reviewer under such sec-
23 tion.

24 “(C) RECEIPT OF BENEFITS DURING AP-
25 PEALS PROCESS.—Receipt by the participant or

1 beneficiary of the benefits involved in the claim
2 for benefits during the pendency of any admin-
3 istrative processes referred to in subparagraph
4 (A) or of any action commenced under this
5 subsection—

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

9 “(ii) shall not preclude any liability
10 under subsection (a)(1)(C) and this sub-
11 section in connection with such claim.

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

17 “(D) CONSIDERATION OF ADMINISTRATIVE
18 DETERMINATIONS.—Any determinations made
19 under section 503C or 503D regarding matters
20 before the court in an action under this section
21 shall be given due consideration by the court in
22 such action.

23 “(5) LIMITATIONS ON RECOVERY OF DAM-
24 AGES.—

1 “(A) MAXIMUM AWARD OF NONECONOMIC
2 DAMAGES.—The aggregate amount of liability
3 for noneconomic damages in an action under
4 paragraph (1) may not exceed \$500,000.

5 “(B) INCREASE IN AMOUNT.—The amount
6 referred to in subparagraph (A) shall be in-
7 creased or decreased, for each calendar year
8 that ends after December 31, 2001, by the
9 same percentage as the percentage by which the
10 Consumer Price Index for All Urban Con-
11 sumers (United States city average), published
12 by the Bureau of Labor Statistics, for Sep-
13 tember of the preceding calendar year has in-
14 creased or decreased from the such Index for
15 September of 2001.

16 “(6) PROHIBITION OF AWARD OF PUNITIVE
17 DAMAGES.—

18 “(A) GENERAL RULE.—Except as provided
19 in this paragraph, nothing in this subsection
20 shall be construed as authorizing a cause of ac-
21 tion for punitive, exemplary, or similar dam-
22 ages.

23 “(B) EXCEPTION.—In addition other dam-
24 ages authorized under paragraph (1), punitive
25 damages are authorized in any case described

1 in such paragraph in which such other damages
2 are authorized and the plaintiff establishes by
3 clear and convincing evidence that conduct car-
4 ried out by the defendant with willful or wanton
5 disregard for the rights or safety of others was
6 the proximate cause of the substantial harm
7 that is the subject of the action.

8 “(C) LIMITATION ON AMOUNT.—

9 “(i) IN GENERAL.—The aggregate
10 amount of liability for punitive damages in
11 an action under paragraph (1) may not ex-
12 ceed \$5,000,000.

13 “(ii) INCREASE IN AMOUNT.—The
14 amount referred to in clause (i) shall be in-
15 creased or decreased, for each calendar
16 year that ends after December 31, 2001,
17 by the same percentage as the percentage
18 by which the Consumer Price Index for All
19 Urban Consumers (United States city av-
20 erage), published by the Bureau of Labor
21 Statistics, for September of the preceding
22 calendar year has increased or decreased
23 from the such Index for September of
24 2001.

1 “(D) NO PUNITIVE DAMAGES WHERE DE-
2 FENDANT’S POSITION PREVIOUSLY SUPPORTED
3 BY MEDICAL REVIEW PANEL UPON EXTERNAL
4 REVIEW.—In any case in which the court finds
5 the defendant to be liable in an action under
6 this subsection, to the extent that—

7 “(i) such liability is based on a find-
8 ing by the court of a particular breach de-
9 scribed in paragraph (1), and

10 “(ii) such finding is contrary to a de-
11 termination by a medical review panel in a
12 decision previously rendered under section
13 503D with respect to such defendant,
14 the defendant shall not be liable for punitive
15 damages under this subsection in connection
16 with such breach.

17 “(7) LIMITATION OF ACTION.—Paragraph (1)
18 shall not apply in connection with any action com-
19 menced after 2 years after the later of—

20 “(A) the date on which the plaintiff first
21 knew, or reasonably should have known, of the
22 personal injury or death resulting from the fail-
23 ure described in paragraph (1), or

24 “(B) the date as of which the requirements
25 of paragraph (4), if applicable, are first met.

1 “(8) PURCHASE OF INSURANCE TO COVER LI-
2 ABILITY.—Nothing in section 410 shall be construed
3 to preclude the purchase by a group health plan of
4 insurance to cover any liability or losses arising
5 under a cause of action under subsection (a)(1)(C)
6 and this subsection.

7 “(9) EXCLUSION OF DIRECTED RECORD-
8 KEEPERS.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (C), paragraph (1) shall not apply with
11 respect to a directed recordkeeper in connection
12 with a group health plan.

13 “(B) DIRECTED RECORDKEEPER.—For
14 purposes of this paragraph, the term ‘directed
15 recordkeeper’ means, in connection with a
16 group health plan, a person engaged in directed
17 recordkeeping activities pursuant to the specific
18 instructions of the plan or the employer or
19 other plan sponsor, including the distribution of
20 enrollment information and distribution of dis-
21 closure materials under this title and whose du-
22 ties do not include making decisions on claims
23 for benefits.

24 “(C) LIMITATION.—Subparagraph (A)
25 does not apply in connection with any directed

1 recordkeeper to the extent that the directed rec-
2 ordkeeper fails to follow the specific instruction
3 of the plan or the employer or other plan spon-
4 sor.

5 “(10) CONSTRUCTION.—Nothing in this sub-
6 section shall be construed as authorizing a cause of
7 action for the failure to provide an item or service
8 which is not covered under the group health plan in-
9 volved.

10 “(11) APPLICABILITY OF STATE LAW.—No pro-
11 vision of State law (as defined in section 514(c)(1))
12 relating to the regulation of quality of care shall be
13 treated as superseded, preempted, or modified by
14 reason of the provisions of subsection (a)(1)(C) and
15 this subsection, nor shall anything in this subsection
16 be construed to supersede, preempt, or modify sec-
17 tion 514 with respect to group health plans or the
18 preemptive effect of this section or section 503D
19 with respect to such plans.

20 “(12) LIMITATION ON CLASS ACTION LITIGA-
21 TION.—A claim or cause of action under this sub-
22 section may not be maintained as a class action.”.

23 (b) EXPANDED REMEDIES FOR EXISTING CAUSES OF
24 ACTION.—

1 (1) IN GENERAL.—Section 502 of such Act (as
2 amended by subsection (a)) is amended further—

3 (A) in subsection (a)(1)(B), by striking
4 “or” before “to clarify” and by striking “plan;”
5 and inserting “plan, or, in the case of a group
6 health plan, for the additional relief provided in
7 subsection (o);”; and

8 (B) by adding after subsection (n) the fol-
9 lowing new subsection:

10 “(o) EXPANDED REMEDIES RELATING TO GROUP
11 HEALTH PLAN DETERMINATIONS THAT ARE NOT MEDI-
12 CALLY REVIEWABLE.—In the case of any determination
13 under a group health plan constituting a denial of a claim
14 for benefits by a participant or beneficiary under the plan
15 which is not a medically reviewable determination, if such
16 determination is the proximate cause of substantial harm
17 to, or wrongful death of, the participant or beneficiary,
18 the relief for which the civil action may be brought under
19 subsection (a)(1)(B) shall include liability of the des-
20 ignated health care decision-maker of the plan for eco-
21 nomic and noneconomic damages in connection with such
22 determination and such substantial harm or death, except
23 that the aggregate amount of such liability for non-
24 economic damages may not exceed the maximum amount
25 allowable under subsection (n)(5).”.

1 (2) SPECIAL RULE.—Nothing in the amend-
2 ment made by paragraph (1) shall affect the stand-
3 ard of review applicable under section 502(a)(1)(B)
4 of the Employee Retirement Income Security Act of
5 1974 (29 U.S.C. 1132(a)(1)(B)).

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to acts and omissions (from which
8 a cause of action arises) occurring on or after the date
9 of the enactment of this Act.

10 **SEC. 202. SEVERABILITY.**

11 If any provision of this title, an amendment made by
12 this title, or the application of such provision or amend-
13 ment to any person or circumstance is held to be unconsti-
14 tutional, the remainder of this title, the amendments made
15 by this title, and the application of the provisions of such
16 to any person or circumstance shall not be affected there-
17 by.

18 **TITLE III—HEALTH CARE COV-**
19 **ERAGE ACCESS TAX INCEN-**
20 **TIVES**

21 **SEC. 301. EXPANDED AVAILABILITY OF MEDICAL SAVINGS**
22 **ACCOUNTS.**

23 (a) REPEAL OF LIMITATIONS ON NUMBER OF MED-
24 ICAL SAVINGS ACCOUNTS.—

1 (1) IN GENERAL.—Subsections (i) and (j) of
2 section 220 of the Internal Revenue Code of 1986
3 are hereby repealed.

4 (2) CONFORMING AMENDMENTS.—

5 (A) Paragraph (1) of section 220(c) of
6 such Code is amended by striking subparagraph
7 (D).

8 (B) Section 138 of such Code is amended
9 by striking subsection (f).

10 (b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR
11 EMPLOYEES OF SMALL EMPLOYERS AND SELF-EM-
12 PLOYED INDIVIDUALS.—

13 (1) IN GENERAL.—Section 220(c)(1)(A) of such
14 Code (relating to eligible individual) is amended to
15 read as follows:

16 “(A) IN GENERAL.—The term ‘eligible in-
17 dividual’ means, with respect to any month, any
18 individual if—

19 “(i) such individual is covered under a
20 high deductible health plan as of the 1st
21 day of such month, and

22 “(ii) such individual is not, while cov-
23 ered under a high deductible health plan,
24 covered under any health plan—

1 “(I) which is not a high deduct-
2 ible health plan, and

3 “(II) which provides coverage for
4 any benefit which is covered under the
5 high deductible health plan.”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) Section 220(c)(1) of such Code is
8 amended by striking subparagraph (C).

9 (B) Section 220(c) of such Code is amend-
10 ed by striking paragraph (4) (defining small
11 employer) and by redesignating paragraph (5)
12 as paragraph (4).

13 (C) Section 220(b) of such Code is amend-
14 ed by striking paragraph (4) (relating to deduc-
15 tion limited by compensation) and by redesign-
16 ating paragraphs (5), (6), and (7) as para-
17 graphs (4), (5), and (6), respectively.

18 (c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED
19 FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

20 (1) IN GENERAL.—Paragraph (2) of section
21 220(b) of such Code is amended to read as follows:

22 “(2) MONTHLY LIMITATION.—The monthly lim-
23 itation for any month is the amount equal to $\frac{1}{12}$ of
24 the annual deductible (as of the first day of such

1 month) of the individual’s coverage under the high
2 deductible health plan.”.

3 (2) CONFORMING AMENDMENT.—Clause (ii) of
4 section 220(d)(1)(A) of such Code is amended by
5 striking “75 percent of”.

6 (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-
7 TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph
8 (4) of section 220(b) of such Code (as redesignated by
9 subsection (b)(2)(C)) is amended to read as follows:

10 “(4) COORDINATION WITH EXCLUSION FOR EM-
11 PLOYER CONTRIBUTIONS.—The limitation which
12 would (but for this paragraph) apply under this sub-
13 section to the taxpayer for any taxable year shall be
14 reduced (but not below zero) by the amount which
15 would (but for section 106(b)) be includible in the
16 taxpayer’s gross income for such taxable year.”.

17 (e) REDUCTION OF PERMITTED DEDUCTIBLES
18 UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

19 (1) IN GENERAL.—Subparagraph (A) of section
20 220(c)(2) of such Code (defining high deductible
21 health plan) is amended—

22 (A) by striking “\$1,500” in clause (i) and
23 inserting “\$1,000”; and

24 (B) by striking “\$3,000” in clause (ii) and
25 inserting “\$2,000”.

1 (2) CONFORMING AMENDMENT.—Subsection (g)
2 of section 220 of such Code is amended to read as
3 follows:

4 “(g) COST-OF-LIVING ADJUSTMENT.—

5 “(1) IN GENERAL.—In the case of any taxable
6 year beginning in a calendar year after 1998, each
7 dollar amount in subsection (c)(2) shall be increased
8 by an amount equal to—

9 “(A) such dollar amount, multiplied by

10 “(B) the cost-of-living adjustment deter-
11 mined under section 1(f)(3) for the calendar
12 year in which such taxable year begins by sub-
13 stituting ‘calendar year 1997’ for ‘calendar year
14 1992’ in subparagraph (B) thereof.

15 “(2) SPECIAL RULES.—In the case of the
16 \$1,000 amount in subsection (c)(2)(A)(i) and the
17 \$2,000 amount in subsection (c)(2)(A)(ii), para-
18 graph (1)(B) shall be applied by substituting ‘cal-
19 endar year 1999’ for ‘calendar year 1997’.

20 “(3) ROUNDING.—If any increase under para-
21 graph (1) or (2) is not a multiple of \$50, such in-
22 crease shall be rounded to the nearest multiple of
23 \$50.”.

1 (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED
2 UNDER CAFETERIA PLANS.—Subsection (f) of section
3 125 of such Code is amended by striking “106(b),”.

4 (g) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2000.

7 (h) GAO STUDY.—Not later than 1 year after the
8 date of the enactment of this Act, the Comptroller General
9 of the United States shall prepare and submit a report
10 to the Committee on Ways and Means of the House of
11 Representatives and the Committee on Finance of the
12 Senate on the impact of medical savings accounts on the
13 cost of conventional insurance (especially in those areas
14 where there are higher numbers of such accounts) and on
15 adverse selection and health care costs.

16 **SEC. 302. DEDUCTION FOR 100 PERCENT OF HEALTH IN-**
17 **SURANCE COSTS OF SELF-EMPLOYED INDI-**
18 **VIDUALS.**

19 (a) IN GENERAL.—Paragraph (1) of section 162(l)
20 of the Internal Revenue Code of 1986 is amended to read
21 as follows:

22 “(1) ALLOWANCE OF DEDUCTION.—In the case
23 of an individual who is an employee within the
24 meaning of section 401(c)(1), there shall be allowed
25 as a deduction under this section an amount equal

1 to 100 percent of the amount paid during the tax-
2 able year for insurance which constitutes medical
3 care for the taxpayer and the taxpayer's spouse and
4 dependents.”.

5 (b) EFFECTIVE DATE.—The amendment made by
6 this section shall apply to taxable years beginning after
7 December 31, 2000.

8 **TITLE IV—HEALTH CARE** 9 **PAPERWORK**

10 **SEC. 401. HEALTH CARE PAPERWORK SIMPLIFICATION.**

11 (a) ESTABLISHMENT OF PANEL.—

12 (1) ESTABLISHMENT.—There is established a
13 panel to be known as the Health Care Panel to De-
14 vise a Uniform Explanation of Benefits (in this sec-
15 tion referred to as the “Panel”).

16 (2) DUTIES OF PANEL.—

17 (A) IN GENERAL.—The Panel shall devise
18 a single form for use by third-party health care
19 payers for the remittance of claims to providers.

20 (B) DEFINITION.—For purposes of this
21 section, the term “third-party health care
22 payer” means any entity that contractually
23 pays health care bills for an individual.

24 (3) MEMBERSHIP.—

1 (A) SIZE AND COMPOSITION.—The Sec-
2 retary of Health and Human Services, in con-
3 sultation with the Majority Leader of the Sen-
4 ate and the Speaker of the House of Represent-
5 atives, shall determine the number of members
6 and the composition of the Panel. Such Panel
7 shall include equal numbers of representatives
8 of private insurance organizations, consumer
9 groups, State insurance commissioners, State
10 medical societies, State hospital associations,
11 and State medical specialty societies.

12 (B) TERMS OF APPOINTMENT.—The mem-
13 bers of the Panel shall serve for the life of the
14 Panel.

15 (C) VACANCIES.—A vacancy in the Panel
16 shall not affect the power of the remaining
17 members to execute the duties of the Panel, but
18 any such vacancy shall be filled in the same
19 manner in which the original appointment was
20 made.

21 (4) PROCEDURES.—

22 (A) MEETINGS.—The Panel shall meet at
23 the call of a majority of its members.

1 (B) FIRST MEETING.—The Panel shall
2 convene not later than 60 days after the date
3 of the enactment of this Act.

4 (C) QUORUM.—A quorum shall consist of
5 a majority of the members of the Panel.

6 (D) HEARINGS.—For the purpose of car-
7 rying out its duties, the Panel may hold such
8 hearings and undertake such other activities as
9 the Panel determines to be necessary to carry
10 out its duties.

11 (5) ADMINISTRATION.—

12 (A) COMPENSATION.—Except as provided
13 in subparagraph (B), members of the Panel
14 shall receive no additional pay, allowances, or
15 benefits by reason of their service on the Panel.

16 (B) TRAVEL EXPENSES AND PER DIEM.—
17 Each member of the Panel who is not an officer
18 or employee of the Federal Government shall
19 receive travel expenses and per diem in lieu of
20 subsistence in accordance with sections 5702
21 and 5703 of title 5, United States Code.

22 (C) CONTRACT AUTHORITY.—The Panel
23 may contract with and compensate government
24 and private agencies or persons for items and

1 services, without regard to section 3709 of the
2 Revised Statutes (41 U.S.C. 5).

3 (D) USE OF MAILS.—The Panel may use
4 the United States mails in the same manner
5 and under the same conditions as Federal agen-
6 cies and shall, for purposes of the frank, be
7 considered a commission of Congress as de-
8 scribed in section 3215 of title 39, United
9 States Code.

10 (E) ADMINISTRATIVE SUPPORT SERV-
11 ICES.—Upon the request of the Panel, the Sec-
12 retary of Health and Human Services shall pro-
13 vide to the Panel on a reimbursable basis such
14 administrative support services as the Panel
15 may request.

16 (6) SUBMISSION OF FORM.—Not later than 2
17 years after the first meeting, the Panel shall submit
18 a form to the Secretary of Health and Human Serv-
19 ices for use by third-party health care payers.

20 (7) TERMINATION.—The Panel shall terminate
21 on the day after submitting its the form under para-
22 graph (6).

23 (b) REQUIREMENT FOR USE OF FORM BY THIRD-
24 PARTY CARE PAYERS.—A third-party health care payer
25 shall be required to use the form devised under subsection

- 1 (a) for plan years beginning on or after 5 years following
- 2 the date of the enactment of this Act.

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