

107TH CONGRESS
1ST SESSION

H. R. 2315

To protect consumers in managed care plans and in other health coverage.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2001

Mr. FLETCHER (for himself, Mr. PETERSON of Minnesota, Mrs. JOHNSON of Connecticut, Mr. BURR of North Carolina, Mr. THOMAS, Mr. TAUZIN, Mr. BOEHNER, Mr. BILIRAKIS, Mr. SAM JOHNSON of Texas, Mr. COOKSEY, Mr. WELDON of Florida, Mr. HAYES, Mr. PENCE, Mr. PLATTS, Ms. PRYCE of Ohio, Mr. GOSS, Mr. HOUGHTON, Mr. GREENWOOD, Mr. PORTMAN, Mr. HOBSON, Mr. HILLEARY, Mr. RADANOVICH, Mr. SIMMONS, Mr. CRENSHAW, Mr. BALLENGER, Mr. GIBBONS, Mr. BUYER, Mr. COLLINS, Mr. PITTS, Mr. ROGERS of Kentucky, Mr. SIMPSON, Mr. LINDER, Mr. SHAW, Mr. WATTS of Oklahoma, Mr. SKEEN, Mr. STEARNS, Mr. BACHUS, Mr. KIRK, Mr. BARTLETT of Maryland, Mr. ENGLISH, Mr. WELLER, Mr. RAMSTAD, Mr. OTTER, Mr. SUNUNU, Mr. LEWIS of Kentucky, Mrs. CUBIN, Mr. ISAKSON, Mr. SHAYS, Mr. WICKER, Mr. PICKERING, Mr. MCINNIS, Mr. MCCRERY, and Mr. CAMP) introduced the following bill; which was referred to the Committee on Energy and 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 protect consumers in managed care plans and in other health coverage.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the
 3 “Patients’ Bill of Rights Act of 2001”.

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. Access to emergency medical care.
- Sec. 102. Offering of choice of coverage options.
- Sec. 103. Patient access to obstetric and gynecological care.
- Sec. 104. Access to pediatric care.
- Sec. 105. Timely access to specialists.
- Sec. 106. Continuity of care.
- Sec. 107. Protection of patient-provider communications.
- Sec. 108. Patient access to prescription drugs.
- Sec. 109. Coverage for individuals participating in approved clinical trials.
- Sec. 110. Prohibition of discrimination against providers based on licensure.
- Sec. 111. Generally applicable provision.

Subtitle B—Right to Information About Plans and Providers

- Sec. 121. Health plan information.
- Sec. 122. Study on the effect of physician compensation methods.

Subtitle C—Right to Hold Health Plans Accountable

- Sec. 131. Amendments to Employee Retirement Income Security Act of 1974.
- Sec. 132. Enforcement.
 - “Sec. 503A. Claims and internal appeals procedures for group health plans.
 - “Sec. 503B. Independent external appeals procedures for group health plans.

Subtitle D—Remedies

- Sec. 141. Availability of court remedies.
- Sec. 142. Treatment of State causes of action with respect to certain claims denials by group health plans.
- Sec. 143. Limitation on certain class action litigation.

Subtitle E—State Flexibility

- Sec. 151. State flexibility in applying requirements to health insurance issuers and non-Federal Governmental group health plans.

Subtitle F—Miscellaneous Provisions

- Sec. 161. Definitions.
- Sec. 162. Exclusions.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

- Sec. 201. Application to certain health insurance coverage.
 Sec. 202. Application to individual health insurance coverage.

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

- Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

TITLE IV—AMENDMENTS TO THE INTERNAL REVENUE CODE OF
1986

- Sec. 401. Application to group health plans under the Internal Revenue Code of 1986.

TITLE V—EFFECTIVE DATE; SEVERABILITY

- Sec. 501. Effective date and related rules.
 Sec. 502. Severability.

TITLE VI—INCREASING ACCESS TO AFFORDABLE HEALTH
INSURANCE

Subtitle A—Tax Incentives

- Sec. 601. Expansion of availability of Archer medical savings accounts.

Subtitle B—Association Health Plans

- Sec. 621. Rules governing association health plans.

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “Sec. 801. Association health plans.
 “Sec. 802. Certification of association health plans.
 “Sec. 803. Requirements relating to sponsors and boards of trustees.
 “Sec. 804. Participation and coverage requirements.
 “Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
 “Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
 “Sec. 807. Requirements for application and related requirements.
 “Sec. 808. Notice requirements for voluntary termination.
 “Sec. 809. Corrective actions and mandatory termination.
 “Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
 “Sec. 811. State assessment authority.
 “Sec. 812. Definitions and rules of construction.
 Sec. 622. Clarification of treatment of single employer arrangements.
 Sec. 623. Clarification of treatment of certain collectively bargained arrangements.
 Sec. 624. Enforcement provisions relating to association health plans.

Sec. 625. Cooperation between Federal and State authorities.

Sec. 626. Effective date and transitional and other rules.

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

5 **SEC. 101. ACCESS TO EMERGENCY MEDICAL CARE.**

6 (a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

18 (C) in a manner so that, if such services
19 are provided to a participant or beneficiary by
20 a nonparticipating health care provider, the
21 participant or beneficiary is not liable for
22 amounts that exceed the amounts of liability
23 that would be incurred if the services were pro-

1 vided by a participating health care provider;
2 and

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

12 (2) DEFINITIONS.—In this section:

13 (A) EMERGENCY MEDICAL CONDITION.—
14 The term “emergency medical condition”
15 means—

16 (i) a medical condition manifesting
17 itself by acute symptoms of sufficient se-
18 verity (including severe pain) such that a
19 prudent layperson, who possesses an aver-
20 age knowledge of health and medicine,
21 could reasonably expect the absence of im-
22 mediate medical attention to result in a
23 condition described in clause (i), (ii), or
24 (iii) of section 1867(e)(1)(A) of the Social
25 Security Act; and

1 (ii) a medical condition manifesting
2 itself in a neonate by acute symptoms of
3 sufficient severity (including severe pain)
4 such that a prudent health care profes-
5 sional could reasonably expect the absence
6 of immediate medical attention to result in
7 a condition described in clause (i), (ii), or
8 (iii) of section 1867(e)(1)(A) of the Social
9 Security Act.

10 (B) EMERGENCY SERVICES.—The term
11 “emergency services” means—

12 (i) with respect to an emergency med-
13 ical condition described in subparagraph
14 (A)(i)—

15 (I) a medical screening examina-
16 tion (as required under section 1867
17 of the Social Security Act) that is
18 within the capability of the emergency
19 department of a hospital, including
20 ancillary services routinely available to
21 the emergency department to evaluate
22 such emergency medical condition,
23 and

24 (II) within the capabilities of the
25 staff and facilities available at the

1 hospital, such further medical exam-
2 ination and treatment as are required
3 under section 1867 of such Act to sta-
4 bilize the patient; or

5 (ii) with respect to an emergency med-
6 ical condition described in subparagraph
7 (A)(ii), medical treatment for such condi-
8 tion rendered by a health care provider in
9 a hospital to a neonate, including available
10 hospital ancillary services in response to an
11 urgent request of a health care profes-
12 sional and to the extent necessary to sta-
13 bilize the neonate.

14 (C) STABILIZE.—The term “to stabilize”,
15 with respect to an emergency medical condition,
16 has the meaning given in section 1867(e)(3) of
17 the Social Security Act (42 U.S.C.
18 1395dd(e)(3)).

19 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND
20 POST-STABILIZATION CARE.—If benefits are available
21 under a group health plan, or under health insurance cov-
22 erage offered by a health insurance issuer, with respect
23 to services that are provided as maintenance care or post-
24 stabilization care covered under the guidelines established
25 under section 1852(d)(2) of the Social Security Act, the

1 plan or issuer shall provide for reimbursement with re-
2 spect to such services provided to a participant or bene-
3 ficiary other than through a participating health care pro-
4 vider in a manner consistent with subsection (a)(1)(C)
5 (and shall otherwise comply with such guidelines).

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

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

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

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

10 **SEC. 102. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

11 (a) REQUIREMENT.—If a group health plan provides
12 coverage for benefits only through a defined set of partici-
13 pating health care professionals, the plan shall offer the
14 participant the option to purchase point-of-service cov-
15 erage (as defined in subsection (b)) for all such benefits
16 (including physician pathology services) for which cov-
17 erage is otherwise so limited. Such option shall be made
18 available to the participant at the time of enrollment
19 under the plan and at such other times as the plan offers
20 the participant a choice of coverage options.

21 (b) POINT-OF-SERVICE COVERAGE DEFINED.—In
22 this section, the term “point-of-service coverage” means,
23 with respect to benefits (including physician pathology
24 services) covered under a group health plan, coverage of

1 such benefits when provided by a nonparticipating health
2 care professional.

3 (c) SMALL EMPLOYER EXEMPTION.—

4 (1) IN GENERAL.—This section shall not apply
5 to any group health plan with respect to a small em-
6 ployer.

7 (2) SMALL EMPLOYER.—For purposes of para-
8 graph (1), the term “small employer” means, in con-
9 nection with a group health plan with respect to a
10 calendar year and a plan year, an employer who em-
11 ployed an average of at least 2 but not more than
12 25 employees on business days during the preceding
13 calendar year and who employs at least 2 employees
14 on the first day of the plan year. For purposes of
15 this paragraph, the provisions of subparagraph (C)
16 of section 712(c)(1) shall apply in determining em-
17 ployer size.

18 (d) RULE OF CONSTRUCTION.—Nothing in this sec-
19 tion shall be construed—

20 (1) as requiring coverage for benefits for a par-
21 ticular type of health care professional;

22 (2) as preventing a group health plan from im-
23 posing higher premiums or cost-sharing on a partici-
24 pant for the exercise of a point-of-service coverage
25 option; or

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

5 **SEC. 103. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**
6 **LOGICAL CARE.**

7 (a) GENERAL RIGHTS.—

8 (1) DIRECT ACCESS.—A group health plan, and
9 health insurance coverage offered by a health insur-
10 ance issuer, described in subsection (b) may not re-
11 quire authorization or referral by the primary care
12 provider described in subsection (b)(2) in the case of
13 a female participant or beneficiary who seeks cov-
14 erage for obstetric or gynecological care provided by
15 a participating physician or by a participating health
16 care professional who specializes in obstetrics or
17 gynecology and is operating within State licensure
18 and scope of practice laws.

19 (2) OBSTETRIC AND GYNECOLOGICAL CARE.—
20 Such a plan or issuer shall treat the provision of ob-
21 stetric and gynecological care, and the ordering of
22 related obstetric and gynecological items and serv-
23 ices, pursuant to the direct access described under
24 paragraph (1), by a participating physician or other
25 health care professional who specializes in obstetrics

1 or gynecology as the authorization of the primary
2 care provider.

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

7 (1) provides coverage for obstetric or gynecolo-
8 gical care; and

9 (2) requires the designation by a participant or
10 beneficiary of a participating primary care provider
11 other than a physician who specializes in obstetrics
12 or gynecology.

13 (c) RULES OF CONSTRUCTION.—Nothing in this sec-
14 tion 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 cov-
19 ered 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 or other health
2 care professional unless such items or services
3 are related to obstetric or gynecological care;

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

13 (3) to preclude a group health plan or health
14 insurance issuer from requiring authorization, in-
15 cluding prior authorization, for items and services
16 (other than routine items and services) from the
17 physician or health care professional described in
18 subsection (a) who specializes in obstetrics and gyne-
19 cology if the designated primary care provider of the
20 participant or beneficiary would otherwise be re-
21 quired to obtain authorization for such items or
22 services.

23 For purposes of paragraph (3), routine items and services
24 includes annual, prenatal, and perinatal examinations.

1 **SEC. 104. ACCESS TO PEDIATRIC CARE.**

2 (a) PEDIATRIC CARE.—If a group health plan, and
3 a health insurance issuer that offers health insurance cov-
4 erage, requires or provides for a participant, beneficiary,
5 or enrollee to designate a participating primary care pro-
6 vider for a child of such participant, beneficiary, or en-
7 rollee, the plan or issuer shall permit the participant, ben-
8 efiary, or enrollee to designate a physician who special-
9 izes in pediatrics as the child’s primary care provider if
10 such provider participates in the network of the plan or
11 issuer.

12 (b) RULES OF CONSTRUCTION.—With respect to the
13 child of a participant, beneficiary, or enrollee, nothing in
14 subsection (a) shall be construed to—

15 (1) require that the participant, beneficiary, or
16 enrollee obtain prior authorization or a referral from
17 a primary care provider in order to obtain pediatric
18 care from a health care professional other than a
19 physician if the provision of pediatric care by such
20 professional is permitted by the plan or issuer and
21 consistent with State licensure, credentialing, and
22 scope of practice laws and regulations; or

23 (2) preclude the participant, beneficiary, or en-
24 rollee from designating a health care professional
25 other than a physician as a primary care provider
26 for the child if such designation is permitted by the

1 plan or issuer and the treatment by such profes-
2 sional is consistent with State licensure,
3 credentialing, and scope of practice laws.

4 **SEC. 105. TIMELY ACCESS TO SPECIALISTS.**

5 (a) TIMELY ACCESS.—

6 (1) IN GENERAL.—A group health plan, or a
7 health insurance issuer offering health insurance
8 coverage, shall ensure that participants and bene-
9 ficiaries receive timely coverage for access to special-
10 ists with respect to the medical condition of the par-
11 ticipant or beneficiary, when such specialty care is a
12 covered benefit under the plan or coverage.

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

15 (A) to require the coverage under a group
16 health plan or health insurance coverage of ben-
17 efits or services;

18 (B) to prohibit a plan or issuer from in-
19 cluding providers in the network only to the ex-
20 tent necessary to meet the needs of the plan’s
21 participants and beneficiaries;

22 (C) to prohibit a plan or issuer from estab-
23 lishing measures designed to maintain quality
24 and control costs consistent with the respon-
25 sibilities of the plan or issuer; or

1 (D) to override any State licensure or
2 scope-of-practice law.

3 (3) ACCESS TO CERTAIN PROVIDERS.—

4 (A) PARTICIPATING PROVIDERS.—Nothing
5 in this section shall be construed to prohibit a
6 group health plan or health insurance issuer
7 from requiring that a participant or beneficiary
8 obtain specialty care from a participating spe-
9 cialist.

10 (B) NONPARTICIPATING PROVIDERS.—

11 (i) IN GENERAL.—With respect to
12 specialty care under this section, if a group
13 health plan or health insurance issuer de-
14 termines that a participating specialist is
15 not available to provide such care to the
16 participant or beneficiary, the plan or
17 issuer shall provide for coverage of such
18 care by a nonparticipating specialist.

19 (ii) TREATMENT OF NONPARTICI-
20 PATING PROVIDERS.—If a group health
21 plan or health insurance issuer refers a
22 participant or beneficiary to a nonpartici-
23 pating specialist pursuant to clause (i),
24 such specialty care shall be provided at no
25 additional cost to the participant or bene-

1 beneficiary beyond what the participant or ben-
2 eficiary would otherwise pay for such spe-
3 cialty care if provided by a participating
4 specialist.

5 (b) REFERRALS.—

6 (1) AUTHORIZATION.—Nothing in this section
7 shall be construed to prohibit a group health plan or
8 health insurance issuer from requiring an authoriza-
9 tion in order to obtain coverage for specialty services
10 so long as such authorization is for an appropriate
11 duration or number of referrals.

12 (2) REFERRALS FOR ONGOING SPECIAL CONDI-
13 TIONS.—

14 (A) IN GENERAL.—A group health plan, or
15 a health insurance issuer offering health insur-
16 ance coverage, shall permit a participant or
17 beneficiary who has an ongoing special condi-
18 tion (as defined in subparagraph (B)) to receive
19 a referral to a specialist for the treatment of
20 such condition and such specialist may author-
21 ize such referrals, procedures, tests, and other
22 medical services with respect to such condition,
23 or coordinate the care for such condition, sub-
24 ject to the terms of a treatment plan referred

1 to in subsection (c) with respect to the condi-
2 tion.

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

7 (i) is life-threatening, degenerative, or
8 disabling; and

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

11 (c) TREATMENT PLANS.—

12 (1) IN GENERAL.—Nothing in this section shall
13 be construed to prohibit a group health plan or
14 health insurance issuer from requiring that specialty
15 care be provided pursuant to a treatment plan so
16 long as the treatment plan is—

17 (A) developed by the specialist, in consulta-
18 tion with the case manager or primary care pro-
19 vider, and the participant or beneficiary;

20 (B) approved by the plan or issuer in a
21 timely manner if the plan or issuer requires
22 such approval; and

23 (C) in accordance with the applicable qual-
24 ity assurance and utilization review standards
25 of the plan or issuer.

1 (2) NOTIFICATION.—Nothing in paragraph (1)
2 shall be construed as prohibiting a group health plan
3 or health insurance issuer from requiring the spe-
4 cialist to provide the plan or issuer with regular up-
5 dates on the specialty care provided, as well as all
6 other necessary medical information.

7 (d) SPECIALIST DEFINED.—For purposes of this sec-
8 tion, the term “specialist” means, with respect to the med-
9 ical condition of the participant or beneficiary, a physician
10 (including an allopathic or osteopathic physician) or health
11 care professional who is appropriately credentialed or li-
12 censed in 1 or more States, who has adequate expertise,
13 appropriate training and experience, and routinely treats
14 the diagnosis or condition of the participant or beneficiary.

15 **SEC. 106. CONTINUITY OF CARE.**

16 (a) TERMINATION OF PROVIDER.—If a contract be-
17 tween a group health plan, and a health insurance issuer
18 that offers health insurance coverage, as appropriate, and
19 a treating health care provider is terminated (as defined
20 in paragraph (e)(4)), or benefits or coverage provided by
21 a health care provider are terminated because of a change
22 in the terms of provider participation in such plan or cov-
23 erage, and an individual who is a participant, beneficiary
24 or enrollee under such plan or coverage is undergoing an
25 active course of treatment for a serious and complex condi-

1 tion, institutional care, pregnancy, or terminal illness from
2 the provider at the time the plan or issuer receives or pro-
3 vides notice of such termination, the plan or issuer shall—

4 (1) notify the individual, or arrange to have the
5 individual notified pursuant to subsection (d)(2), on
6 a timely basis of such termination;

7 (2) provide the individual with an opportunity
8 to notify the plan or issuer of the individual's need
9 for transitional care; and

10 (3) subject to subsection (e), permit the indi-
11 vidual to elect to continue to be covered with respect
12 to the active course of treatment with the provider's
13 consent during a transitional period (as provided for
14 under subsection (b)).

15 Nothing in this section shall be construed as preventing
16 a plan or issuer from providing the notice under para-
17 graph (1) before the effective date of the provider's termi-
18 nation.

19 (b) TRANSITIONAL PERIOD.—

20 (1) SERIOUS AND COMPLEX CONDITIONS.—The
21 transitional period under this section with respect to
22 a serious and complex condition shall extend for up
23 to 90 days from the date of the notice described in
24 subsection (a)(1) of the provider's termination.

25 (2) INSTITUTIONAL OR INPATIENT CARE.—

1 (A) IN GENERAL.—The transitional period
2 under this section for institutional or non-elec-
3 tive inpatient care from a provider shall extend
4 until the earlier of—

5 (i) the expiration of the 90-day period
6 beginning on the date on which the notice
7 described in subsection (a)(1) of the pro-
8 vider’s termination is provided; or

9 (ii) the date of discharge of the indi-
10 vidual from such care or the termination of
11 the period of institutionalization.

12 (B) SCHEDULED CARE.—The 90 day limi-
13 tation described in subparagraph (A)(i) shall in-
14 clude post-surgical follow-up care relating to
15 non-elective surgery that has been scheduled be-
16 fore the date of the notice of the termination of
17 the provider under subsection (a)(1).

18 (3) PREGNANCY.—If—

19 (A) a participant, beneficiary, or enrollee
20 was pregnant at the time of a provider’s termi-
21 nation of participation; and

22 (B) the provider was treating the preg-
23 nancy before the date of the termination;
24 the transitional period under this subsection with re-
25 spect to provider’s treatment of the pregnancy shall

1 extend through the provision of post-partum care di-
2 rectly related to the delivery.

3 (4) TERMINAL ILLNESS.—If—

4 (A) a participant, beneficiary, or enrollee
5 was determined to be terminally ill (as deter-
6 mined under section 1861(dd)(3)(A) of the So-
7 cial Security Act) at the time of a provider’s
8 termination of participation; and

9 (B) the provider was treating the terminal
10 illness before the date of termination;

11 the transitional period under this subsection shall
12 extend for the remainder of the individual’s life for
13 care that is directly related to the treatment of the
14 terminal illness.

15 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
16 group health plan, and a health insurance issuer that of-
17 fers health insurance coverage, may condition coverage of
18 continued treatment by a provider under this section upon
19 the provider agreeing, in advance in writing, to the fol-
20 lowing:

21 (1) The treating health care provider agrees to
22 accept reimbursement from the plan or issuer and
23 individual involved (with respect to cost-sharing) at
24 the rates applicable prior to the start of the transi-
25 tional period as payment in full (or at the rates ap-

1 plicable under the replacement plan after the date of
2 the termination of the contract with the plan or
3 issuer) and not to impose cost-sharing with respect
4 to the individual in an amount that would exceed the
5 cost-sharing that could have been imposed if the
6 contract referred to in this section had not been ter-
7 minated (or, if applicable, at the cost-sharing appli-
8 cable under the replacement plan).

9 (2) The treating health care provider agrees to
10 adhere to the quality assurance standards of the
11 plan or issuer responsible for payment under para-
12 graph (1) and to provide to such plan or issuer nec-
13 essary medical information related to the care pro-
14 vided.

15 (3) The treating health care provider agrees
16 otherwise to adhere to such plan's or issuer's policies
17 and procedures, including procedures regarding re-
18 ferrals and obtaining prior authorization and pro-
19 viding services pursuant to a treatment plan (if any)
20 approved by the plan or issuer.

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

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

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

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

7 (B) provide the plan or issuer with the
8 name of each participant, beneficiary, or en-
9 rollee who the provider believes is eligible for
10 transitional care under this section.

11 (e) DEFINITIONS.—In this section:

12 (1) CONTRACT.—The term “contract between a
13 group health plan, and a health insurance issuer
14 that offers health insurance coverage, and a treating
15 health care provider” shall include a contract be-
16 tween such a plan or issuer and an organized net-
17 work of providers.

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

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

1 (B) any entity that is engaged in the deliv-
2 ery of health care services in a State and that,
3 if it is required by State law or regulation to be
4 licensed or certified by the State to engage in
5 the delivery of such services in the State, is so
6 licensed.

7 (3) SERIOUS AND COMPLEX CONDITION.—The
8 term “serious and complex condition” means, with
9 respect to a participant, beneficiary, or enrollee
10 under the plan or coverage, a condition that is medi-
11 cally determinable and—

12 (A) in the case of an acute illness, is a
13 condition serious enough to require specialized
14 medical treatment to avoid the reasonable possi-
15 bility of death or permanent harm; or

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

18 (i) is complex and difficult to manage;

19 (ii) is disabling or life- threatening;

20 and

21 (iii) requires—

22 (I) frequent monitoring over a
23 prolonged period of time and requires
24 substantial on-going specialized med-
25 ical care; or

1 (II) frequent ongoing specialized
2 medical care across a variety of do-
3 mains of care.

4 (4) TERMINATED.—The term “terminated” in-
5 cludes, with respect to a contract (as defined in
6 paragraph (1)), the expiration or nonrenewal of the
7 contract with the provider by the group health plan
8 or health insurance issuer, but does not include a
9 termination of the contract by the plan or issuer for
10 failure to meet applicable quality standards or for
11 fraud.

12 **SEC. 107. PROTECTION OF PATIENT-PROVIDER COMMU-**
13 **NICATIONS.**

14 (a) IN GENERAL.—Subject to subsection (b), a group
15 health plan, and a health insurance issuer that offers
16 health insurance coverage, (in relation to a participant,
17 beneficiary, or enrollee) shall not prohibit or otherwise re-
18 strict a health care professional from advising such a par-
19 ticipant, beneficiary, or enrollee who is a patient of the
20 professional about the health status of the participant,
21 beneficiary, or enrollee or medical care or treatment for
22 the condition or disease of the participant, beneficiary, or
23 enrollee, regardless of whether coverage for such care or
24 treatment are provided under the contract, if the profes-
25 sional is acting within the lawful scope of practice.

1 (b) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed as requiring a group health plan,
3 or a health insurance issuer that offers health insurance
4 coverage, to provide specific benefits under the terms of
5 such plan or coverage.

6 (c) NULLIFICATION.—Any contract provision that re-
7 stricts or prohibits medical communications in violation of
8 subsection (a) shall be null and void.

9 **SEC. 108. PATIENT ACCESS TO PRESCRIPTION DRUGS.**

10 (a) IN GENERAL.—To the extent that a group health
11 plan, and a health insurance issuer that offers health in-
12 surance coverage, provides coverage for benefits with re-
13 spect to prescription drugs, and limits such coverage to
14 drugs included in a formulary, the plan or issuer shall—

15 (1) ensure the establishment of a pharma-
16 ceutical and therapeutic committee that develops the
17 formulary, the majority of the members of which
18 must be individuals who are physicians or phar-
19 macists; and

20 (2) in accordance with the applicable quality as-
21 surance and utilization review standards of the plan
22 or issuer, provide for exceptions from the formulary
23 limitation when—

1 (A) the prescribing physician (or the pre-
2 scribing health care professional) requests such
3 an exception;

4 (B) the drugs on the formulary within a
5 therapeutic class—

6 (i) are (or are likely to be) not as ef-
7 fective for the specific patient as the non-
8 formulary drug, or

9 (ii) in comparison with the non-for-
10 mulary drug, have (or are likely to have)
11 greater significant adverse side-effects for
12 the specific patient; and

13 (C) the non-formulary drug is medically
14 necessary and appropriate for the specific pa-
15 tient.

16 (b) RULE OF CONSTRUCTION.—Nothing in this sec-
17 tion shall be construed to prohibit a group health plan,
18 or a health insurance issuer that offers health insurance
19 coverage, from excluding coverage for a specific drug or
20 class of drugs if such drugs or class of drugs is expressly
21 excluded under the terms and conditions of the plan or
22 coverage.

23 (c) INFORMATION DISCLOSURE REQUIRED.—Disclo-
24 sure to patients and physicians of information on for-

1 mulary restrictions is required under subsections (a),
2 (b)(10), and (c)(2) of section 121(a).

3 **SEC. 109. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**
4 **APPROVED CLINICAL TRIALS.**

5 (a) COVERAGE.—

6 (1) IN GENERAL.—If a group health plan, and
7 a health insurance issuer that offers health insur-
8 ance coverage, provides coverage to a qualified indi-
9 vidual (as defined in subsection (b)), the plan or
10 issuer—

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

14 (B) subject to subsections (b), (c), and (d)
15 may not deny (or limit or impose additional
16 conditions on) the coverage of routine patient
17 costs for items and services furnished in con-
18 nection with participation in the trial; and

19 (C) may not discriminate against the indi-
20 vidual on the basis of the participant's, bene-
21 ficiaries, or enrollee's participation in such trial.

22 (2) EXCLUSION OF CERTAIN COSTS.—For pur-
23 poses of this section, routine patient costs do not in-
24 clude costs of items and services (including transpor-
25 tation, tests, measurements, and procedures) that

1 are provided primarily for the purpose of the clinical
2 trial involved or that otherwise are reasonably ex-
3 pected (as determined by the Secretary) to be paid
4 for by the sponsors of an approved clinical trial.

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

13 (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-
14 poses of subsection (a), the term “qualified individual”
15 means an individual who is a participant or beneficiary
16 in a group health plan or an enrollee in health insurance
17 coverage and who meets all the following conditions:

18 (1)(A) The individual has a life-threatening or
19 serious illness for which no standard treatment is ef-
20 fective.

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

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

4 (2) Either—

5 (A) the referring physician is a partici-
6 pating health care professional and has con-
7 cluded that the individual's participation in
8 such trial would be appropriate based upon the
9 individual meeting the conditions described in
10 paragraph (1); or

11 (B) the participant, beneficiary, or enrollee
12 provides medical and scientific information es-
13 tablishing that the individual's participation in
14 such trial would be appropriate based upon the
15 individual meeting the conditions described in
16 paragraph (1).

17 (c) PAYMENT.—

18 (1) IN GENERAL.—Under this section a group
19 health plan, and a health insurance issuer offering
20 health insurance coverage, shall provide for payment
21 for routine patient costs consistent with subsection
22 (a)(2).

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

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

3 (B) a nonparticipating provider, the pay-
4 ment rate shall be at the rate the plan would
5 normally pay for comparable services under
6 subparagraph (A).

7 (d) APPROVED CLINICAL TRIAL DEFINED.—

8 (1) IN GENERAL.—In this section, the term
9 “approved clinical trial” means a clinical research
10 study or clinical investigation approved or funded
11 (which may include funding through in-kind con-
12 tributions) by one or more of the following:

13 (A) The National Institutes of Health.

14 (B) A cooperative group or center of the
15 National Institutes of Health.

16 (C) The Food and Drug Administration,
17 but only with respect to cancer clinical research
18 studies or cancer clinical investigations.

19 (D) Either of the following if the condi-
20 tions described in paragraph (2) are met:

21 (i) The Department of Veterans Af-
22 fairs.

23 (ii) The Department of Defense.

24 (2) CONDITIONS FOR DEPARTMENTS.—The
25 conditions described in this paragraph, for a study

1 or investigation conducted by a Department, are
2 that the study or investigation has been reviewed
3 and approved through a system of peer review that
4 the Secretary determines—

5 (A) to be comparable to the system of peer
6 review of studies and investigations used by the
7 National Institutes of Health, and

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

11 (e) CONSTRUCTION.—Nothing in this section shall be
12 construed to preclude a plan or issuer from offering cov-
13 erage that is broader than the coverage required under
14 this section with respect to clinical trials.

15 (f) PLAN SATISFACTION OF CERTAIN REQUIRE-
16 MENTS; RESPONSIBILITIES OF FIDUCIARIES.—

17 (1) IN GENERAL.—For purposes of this section,
18 insofar as a group health plan provides benefits in
19 the form of health insurance coverage through a
20 health insurance issuer, the plan shall be treated as
21 meeting the requirements of this section with respect
22 to such benefits and not be considered as failing to
23 meet such requirements because of a failure of the
24 issuer to meet such requirements so long as the plan

1 sponsor or its representatives did not cause such
2 failure by the issuer.

3 (2) CONSTRUCTION.—Nothing in this section
4 shall be construed to affect or modify the respon-
5 sibilities of the fiduciaries of a group health plan
6 under part 4 of subtitle B of title I of the Employee
7 Retirement Income Security Act of 1974.

8 (g) STUDY AND REPORT.—

9 (1) STUDY.—The Secretary shall study the im-
10 pact on group health plans and health insurance
11 issuers for covering routine patient care costs for in-
12 dividuals who are entitled to benefits under this sec-
13 tion and who are enrolled in an approved clinical
14 trial program.

15 (2) REPORT TO CONGRESS.—Not later than
16 January 1, 2006, the Secretary shall submit a re-
17 port to Congress that contains an assessment of—

18 (A) any incremental cost to group health
19 plans and health insurance issuers resulting
20 from the provisions of this section;

21 (B) a projection of expenditures to such
22 plans and issuers resulting from this section;
23 and

24 (C) any impact on premiums resulting
25 from this section.

1 **SEC. 110. PROHIBITION OF DISCRIMINATION AGAINST PRO-**
2 **VIDERS BASED ON LICENSURE.**

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

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

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

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

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

1 (4) as prohibiting a family practice physician
2 with appropriate expertise from providing pediatric,
3 obstetric, gynecological, or other appropriate care.

4 **SEC. 111. GENERALLY APPLICABLE PROVISION.**

5 Notwithstanding section 102, in the case of a group
6 health plan, and a health insurance issuer that offers
7 health insurance coverage, that provides benefits under 2
8 or more coverage options, the requirements of this subtitle
9 shall apply separately with respect to each coverage op-
10 tion.

11 **Subtitle B—Right to Information**
12 **About Plans and Providers**

13 **SEC. 121. HEALTH PLAN INFORMATION.**

14 (a) REQUIREMENT.—

15 (1) DISCLOSURE.—

16 (A) IN GENERAL.—A group health plan,
17 and a health insurance issuer that offers health
18 insurance coverage, shall provide for the disclo-
19 sure of the information described in subsection
20 (b) to participants, beneficiaries, and
21 enrollees—

22 (i) at the time of the initial enrollment
23 of the participant, beneficiary, or enrollee
24 under the plan or coverage;

1 (ii) on an annual basis after
2 enrollment—

3 (I) in conjunction with the elec-
4 tion period of the plan or coverage if
5 the plan or coverage has such an elec-
6 tion period; or

7 (II) in the case of a plan or cov-
8 erage that does not have an election
9 period, in conjunction with the begin-
10 ning of the plan or coverage year; and

11 (iii) in the case of any material reduc-
12 tion to the benefits or information de-
13 scribed in paragraphs (1), (2) and (3) of
14 subsection (b), in the form of a summary
15 notice provided not later than the date on
16 which the reduction takes effect.

17 (B) PARTICIPANTS, BENEFICIARIES, OR
18 ENROLLEES.—The disclosure required under
19 subparagraph (A) shall be provided—

20 (i)(I) jointly to each participant and
21 beneficiary who reside at the same address;
22 or

23 (II) in the case of a beneficiary who
24 does not reside at the same address as the

1 participant, separately to the participant
2 and such beneficiary; and

3 (ii) to each enrollee.

4 (2) DISCLOSURE OF PRESCRIPTION DRUG IN-
5 FORMATION TO PARTICIPATING PHYSICIANS.—A
6 group health plan, and a health insurance issuer
7 that offers health insurance coverage, shall provide
8 for the disclosure of the information described in
9 subsection (b)(10) and in subsection (c)(2) to par-
10 ticipating physicians upon request.

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

20 (4) RULE OF CONSTRUCTION.—Nothing in this
21 section shall be construed to prevent a group health
22 plan sponsor and health insurance issuer from enter-
23 ing into an agreement under which either the plan
24 sponsor or the issuer agrees to assume responsibility
25 for compliance with the requirements of this section,

1 in whole or in part, and the party delegating such
2 responsibility is released from liability for compli-
3 ance with the requirements that are assumed by the
4 other party, to the extent the party delegating such
5 responsibility did not cause such noncompliance.

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

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

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

13 (B) specific preventative services covered
14 under the plan or coverage if such services are
15 covered;

16 (C) any benefit limitations, including any
17 annual or lifetime benefit limits and any mone-
18 tary limits or limits on the number of visits,
19 days, or services, and any specific coverage ex-
20 clusions; and

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

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

1 (A) any premiums, deductibles, coinsur-
2 ance, copayment amounts, and liability for bal-
3 ance billing above any reasonable and cus-
4 tomary charges, for which the participant, bene-
5 ficiary, or enrollee will be responsible under
6 each option available under the plan;

7 (B) any maximum out-of-pocket expense
8 for which the participant, beneficiary, or en-
9 rollee may be liable;

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

13 (D) any additional cost-sharing or charges
14 for benefits and services that are furnished
15 without meeting applicable plan or coverage re-
16 quirements, such as prior authorization or
17 precertification.

18 (3) SERVICE AREA.—A description of the plan
19 or issuer’s service area, including the provision of
20 any out-of-area coverage.

21 (4) PARTICIPATING PROVIDERS.—A directory of
22 participating providers (to the extent a plan or
23 issuer provides coverage through a network of pro-
24 viders) that includes, at a minimum, the name, ad-
25 dress, and telephone number of each participating

1 provider, and information about how to inquire
2 whether a participating provider is currently accept-
3 ing new patients.

4 (5) CHOICE OF PRIMARY CARE PROVIDER.—A
5 description of any requirements and procedures to
6 be used by participants, beneficiaries, and enrollees
7 in selecting, accessing, or changing their primary
8 care provider, including providers both within and
9 outside of the network (if the plan or issuer permits
10 out-of-network services), and the right to select a pe-
11 diatrician as a primary care provider under section
12 104 for a participant, beneficiary, or enrollee who is
13 a child if such section applies.

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

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

24 (8) SPECIALTY CARE.—A description of the re-
25 quirements and procedures to be used by partici-

1 pants, beneficiaries, and enrollees in accessing spe-
2 cialty care and obtaining referrals to participating
3 and nonparticipating specialists, including the right
4 to timely coverage for access to specialists care
5 under section 105 if such section applies.

6 (9) CLINICAL TRIALS.—A description the cir-
7 cumstances and conditions under which participation
8 in clinical trials is covered under the terms and con-
9 ditions of the plan or coverage, and the right to ob-
10 tain coverage for approved cancer clinical trials
11 under section 109 if such section applies.

12 (10) PRESCRIPTION DRUGS.—To the extent the
13 plan or issuer provides coverage for prescription
14 drugs, a statement of whether such coverage is lim-
15 ited to drugs included in a formulary, a description
16 of any provisions and cost-sharing required for ob-
17 taining on- and off-formulary medications, and a de-
18 scription of the rights of participants, beneficiaries,
19 and enrollees in obtaining access to access to pre-
20 scription drugs under section 107 if such section ap-
21 plies.

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

1 under the prudent layperson standard under section
2 101, if such section applies, and any educational in-
3 formation that the plan or issuer may provide re-
4 garding the appropriate use of emergency services.

5 (12) CLAIMS AND APPEALS.—A description of
6 the plan or issuer’s rules and procedures pertaining
7 to claims and appeals, a description of the rights of
8 participants, beneficiaries, or enrollees under sec-
9 tions 503, 503A and 503B of the Employee Retire-
10 ment Income Security Act of 1974 (or sections
11 2707(b) and 2753(b) of the Public Health Service
12 with respect to non-Federal governmental plans and
13 individual health insurance coverage) in obtaining
14 covered benefits, filing a claim for benefits, and ap-
15 pealing coverage determinations internally and exter-
16 nally (including telephone numbers and mailing ad-
17 dresses of the appropriate authority), and a descrip-
18 tion of any additional legal rights and remedies
19 available under section 502 of the Employee Retire-
20 ment Income Security Act of 1974.

21 (13) ADVANCE DIRECTIVES AND ORGAN DONA-
22 TION.—A description of procedures for advance di-
23 rectives and organ donation decisions if the plan or
24 issuer maintains such procedures.

1 (14) INFORMATION ON PLANS AND ISSUERS.—

2 The name, mailing address, and telephone number
3 or numbers of the plan administrator and the issuer
4 to be used by participants, beneficiaries, and enroll-
5 ees seeking information about plan or coverage bene-
6 fits and services, payment of a claim, or authoriza-
7 tion for services and treatment. The name of the
8 designated decisionmaker (or decisionmakers) ap-
9 pointed under section 502(n)(2) of the Employee
10 Retirement Income Security Act of 1974 for pur-
11 poses of making final determinations under section
12 503A of such Act and approving coverage pursuant
13 to the written determination of an independent med-
14 ical reviewer under section 503B of such Act. Notice
15 of whether the benefits under the plan are provided
16 under a contract or policy of insurance issued by an
17 issuer, or whether benefits are provided directly by
18 the plan sponsor who bears the insurance risk.

19 (15) TRANSLATION SERVICES.—A summary de-
20 scription of any translation or interpretation services
21 (including the availability of printed information in
22 languages other than English, audio tapes, or infor-
23 mation in Braille) that are available for non-English
24 speakers and participants, beneficiaries, and enroll-

1 ees with communication disabilities and a description
2 of how to access these items or services.

3 (16) ACCREDITATION INFORMATION.—Any in-
4 formation that is made public by accrediting organi-
5 zations in the process of accreditation if the plan or
6 issuer is accredited, or any additional quality indica-
7 tors (such as the results of enrollee satisfaction sur-
8 veys) that the plan or issuer makes public or makes
9 available to participants, beneficiaries, and enrollees.

10 (17) NOTICE OF REQUIREMENTS.—A descrip-
11 tion of any rights of participants, beneficiaries, and
12 enrollees that are established by this Act (excluding
13 those described in paragraphs (1) through (16)) if
14 such rights apply. The description required under
15 this paragraph may be combined with the notices re-
16 quired under sections 711(d), 713(b), or 606(a)(1)
17 of the Employee Retirement Income Security Act of
18 1974, and with any other notice provision that the
19 Secretary determines may be combined.

20 (18) COMPENSATION METHODS.—A summary
21 description of the methods (including capitation, fee-
22 for-service, salary, withholds, bonuses, bundled pay-
23 ments, per diem, or a combination thereof) used for
24 compensating participating health care professionals
25 (including primary care providers and specialists)

1 and facilities in connection with the provision of
2 health care under the plan or coverage. The require-
3 ment of this paragraph shall not be construed as re-
4 quiring plans or issuers to provide information con-
5 cerning proprietary payment methodology.

6 (19) AVAILABILITY OF ADDITIONAL INFORMA-
7 TION.—A statement that the information described
8 in subsection (c), and instructions on obtaining such
9 information (including telephone numbers and, if
10 available, Internet websites), shall be made available
11 upon request.

12 (c) ADDITIONAL INFORMATION.—The informational
13 materials to be provided upon the request of a participant,
14 beneficiary, or enrollees shall include for each option avail-
15 able under a group health plan and health insurance cov-
16 erage the following:

17 (1) STATUS OF PROVIDERS.—The State licen-
18 sure status of the plan or issuer’s participating
19 health care professionals and participating health
20 care facilities, and, if available, the education, train-
21 ing, specialty qualifications or certifications of such
22 professionals.

23 (2) PRESCRIPTION DRUGS.—Information about
24 whether a specific prescription medication is in-

1 cluded in the formulary of the plan or issuer, if the
2 plan or issuer uses a defined formulary.

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

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

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

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

21 (2) complying with the provisions of this section
22 by providing information in brochures, through the
23 Internet or other electronic media, or through other
24 similar means, so long as participants, beneficiaries,
25 and enrollees are provided with an opportunity to re-

1 quest that informational materials be provided in
2 printed form.

3 (f) CONFORMING REGULATIONS.—The Secretary
4 shall issue regulations to coordinate the requirements on
5 group health plans and health insurance issuers under this
6 section with the requirements imposed under part 1, to
7 reduce duplication with respect to any information that
8 is required to be provided under any such requirements.

9 (g) SECRETARIAL ENFORCEMENT AUTHORITY.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services or the Secretary of Labor (as ap-
12 propriate) may assess a civil monetary penalty
13 against the administrator of a plan or issuer in con-
14 nection with the failure of the plan or issuer to com-
15 ply with the requirements of this section.

16 (2) AMOUNT OF PENALTY.—The amount of the
17 penalty to be imposed under paragraph (1) shall not
18 exceed \$100 for each day for each participant, bene-
19 ficiary, or enrollee with respect to which the failure
20 to comply with the requirements of this section oc-
21 curs.

22 (3) FAILURE DEFINED.—For purposes of this
23 subsection, a plan or issuer shall have failed to com-
24 ply with the requirements of this section with re-
25 spect to a participant, beneficiary, or enrollee if the

1 plan or issuer failed or refused to comply with the
2 requirements of this section within 30 days—

3 (A) of the date described in subsection
4 (a)(1)(A)(i);

5 (B) of the date described in subsection
6 (a)(1)(A)(ii); or

7 (C) of the date on which additional infor-
8 mation was requested under subsection (c).

9 (h) CONFORMING AMENDMENTS.—

10 (1) Section 732(a) of the Employee Retirement
11 Income Security Act of 1974 (29 U.S.C. 1191a(a))
12 is amended by striking “section 711” and inserting
13 “section 711 and section 121 of the Patients’ Bill of
14 Rights Act of 2001”.

15 (2) Section 502(b)(3) of the Employee Retire-
16 ment Income Security Act of 1974 (29 U.S.C.
17 1132(b)(3)) is amended by striking “733(a)(1)”
18 and inserting “733(a)(1)), except with respect to the
19 requirements of section 121 of the Patients’ Bill of
20 Rights Act of 2001”.

21 **SEC. 122. STUDY ON THE EFFECT OF PHYSICIAN COM-**
22 **PENSATION METHODS.**

23 (a) STUDY AND REPORT.—

24 (1) IN GENERAL.—The Secretary shall enter
25 into a contract with the Institute of Medicine for the

1 conduct of a study in accordance with this section,
2 to be submitted to the Secretary and the Secretary
3 of Labor as provided for in paragraph (4).

4 (2) MATTERS TO BE STUDIED.—The study
5 under paragraph (1) shall include—

6 (A) a study, including a survey if nec-
7 essary, of physician compensation arrangements
8 that are utilized in employer-sponsored group
9 health plans (including group health plans
10 sponsored by government and non-government
11 employers) and commercial health insurance
12 products, including—

13 (i) all types of compensation arrange-
14 ments, including financial incentive and
15 risk sharing arrangements and arrange-
16 ments that do not contain such incentives
17 and risk sharing, that reflect the com-
18 plexity of organizational relationships be-
19 tween health plans and physicians;

20 (ii) arrangements that are based on
21 factors such as utilization management,
22 cost control, quality improvement, and pa-
23 tient or enrollee satisfaction; and

24 (iii) arrangements between the plan or
25 issuer and provider, as well as down-

1 stream arrangements between providers
2 and sub-contracted providers;

3 (B) an analysis of the effect of such dif-
4 fering arrangements on physician behavior with
5 respect to the provision of medical care to pa-
6 tients, including whether and how such arrange-
7 ments affect the quality of patient care and the
8 ability of physicians to provide care that is
9 medically necessary and appropriate.

10 (3) STUDY DESIGN.—The Secretary shall con-
11 sult with the Director of the Agency for Healthcare
12 Research and Quality in preparing the scope of work
13 and study design with respect to the contract under
14 paragraph (1).

15 (4) REPORT.—Not later than 24 months after
16 the date of enactment of this Act, the Secretary
17 shall forward to the appropriate committees of Con-
18 gress a copy of the report and study conducted
19 under subsection (a).

20 (b) RESEARCH.—

21 (1) IN GENERAL.—The Secretary, acting
22 through the Director of the Agency for Healthcare
23 Research and Quality, shall conduct and support re-
24 search to develop scientific evidence regarding the
25 effects of differing physician compensation methods

1 on physician behavior with respect to the provision
2 of medical care to patients, particularly issues relat-
3 ing to the quality of patient care and whether pa-
4 tients receive medically necessary and appropriate
5 care.

6 (2) AUTHORIZATION OF APPROPRIATIONS.—For
7 purposes of carrying out this section, there are au-
8 thorized to be appropriated such sums as may be
9 necessary.

10 **Subtitle C—Right to Hold Health** 11 **Plans Accountable**

12 **SEC. 131. AMENDMENTS TO EMPLOYEE RETIREMENT IN-** 13 **COME SECURITY ACT OF 1974.**

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

18 **“SEC. 503A. CLAIMS AND INTERNAL APPEALS PROCEDURES** 19 **FOR GROUP HEALTH PLANS.**

20 “(a) INITIAL CLAIM FOR BENEFITS UNDER GROUP
21 HEALTH PLANS.—

22 “(1) PROCEDURES.—

23 “(A) IN GENERAL.—A group health plan,
24 and a health insurance issuer that offers health
25 insurance coverage in connection with a group

1 health plan, shall ensure that procedures are in
2 place for—

3 “(i) making a determination on an
4 initial claim for benefits by a participant
5 or beneficiary (or authorized representa-
6 tive) regarding payment or coverage for
7 items or services under the terms and con-
8 ditions of the plan or coverage involved, in-
9 cluding any cost-sharing amount that the
10 participant or beneficiary is required to
11 pay with respect to such claim for benefits;
12 and

13 “(ii) notifying a participant or bene-
14 ficiary (or authorized representative) and
15 the treating health care professional in-
16 volved regarding a determination on an ini-
17 tial claim for benefits made under the
18 terms and conditions of the plan or cov-
19 erage, including any cost-sharing amounts
20 that the participant or beneficiary may be
21 required to make with respect to such
22 claim for benefits, and of the right of the
23 participant or beneficiary to an internal
24 appeal under subsection (b).

1 “(B) ACCESS TO INFORMATION.—With re-
2 spect to an initial claim for benefits, the partici-
3 pant or beneficiary (or authorized representa-
4 tive) and the treating health care professional
5 (if any) shall provide the plan or issuer with ac-
6 cess to information requested by the plan or
7 issuer that is necessary to make a determina-
8 tion relating to the claim, not later than 5 days
9 after the date on which the claim is filed or to
10 meet the applicable timelines under clauses (ii)
11 and (iii) of paragraph (2)(A).

12 “(C) ORAL REQUESTS.—In the case of a
13 claim for benefits involving an expedited or con-
14 current determination, a participant or bene-
15 ficiary (or authorized representative) may make
16 an initial claim for benefits orally, but a group
17 health plan, or health insurance issuer that of-
18 fers health insurance coverage in connection
19 with a group health plan, may require that the
20 participant or beneficiary (or authorized rep-
21 resentative) provide written confirmation of
22 such request in a timely manner.

23 “(2) TIMELINE FOR MAKING DETERMINA-
24 TIONS.—

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

3 “(i) IN GENERAL.—A group health
4 plan, and a health insurance issuer that of-
5 fers health insurance coverage in connec-
6 tion with a group health plan, shall main-
7 tain procedures to ensure that a prior au-
8 thorization determination on a claim for
9 benefits is made within 14 days from the
10 date on which the plan or issuer receives
11 information that is reasonably necessary to
12 enable the plan or issuer to make a deter-
13 mination on the request for prior author-
14 ization, but in no case shall such deter-
15 mination be made later than 21 days after
16 the receipt of the claim for benefits.

17 “(ii) EXPEDITED DETERMINATION.—
18 Notwithstanding clause (i), a group health
19 plan, and a health insurance issuer that of-
20 fers health insurance coverage in connec-
21 tion with a group health plan, shall main-
22 tain procedures for expediting a prior au-
23 thorization determination on a claim for
24 benefits described in such clause when a
25 request for such an expedited determina-

1 tion is made by a participant or beneficiary
2 (or authorized representative) at any time
3 during the process for making a deter-
4 mination and the treating health care pro-
5 fessional substantiates, with the request,
6 that a determination under the procedures
7 described in clause (i) would seriously jeop-
8 ardize the life or health of the participant
9 or beneficiary. Such determination shall be
10 made within 72 hours after a request is re-
11 ceived by the plan or issuer under this
12 clause.

13 “(iii) CONCURRENT DETERMINA-
14 TIONS.—A group health plan, and a health
15 insurance issuer that offers health insur-
16 ance coverage in connection with a group
17 health plan, shall maintain procedures to
18 ensure that a concurrent determination on
19 a claim for benefits that results in a dis-
20 continuation of inpatient care is made
21 within 24 hours after the receipt of the
22 claim for benefits.

23 “(B) RETROSPECTIVE DETERMINATION.—
24 A group health plan, and a health insurance
25 issuer that offers health insurance coverage in

1 connection with a group health plan, shall
2 maintain procedures to ensure that a retrospec-
3 tive determination on a claim for benefits is
4 made within 30 days of the date on which the
5 plan or issuer receives information that is rea-
6 sonably necessary to enable the plan or issuer
7 to make a determination on the claim, but in no
8 case shall such determination be made later
9 than 60 days after the receipt of the claim for
10 benefits.

11 “(3) NOTICE OF A DENIAL OF A CLAIM FOR
12 BENEFITS.—Written notice of a denial made under
13 an initial claim for benefits shall be issued to the
14 participant or beneficiary (or authorized representa-
15 tive) and the treating health care professional not
16 later than 2 days after the determination (or within
17 the 72-hour or 24-hour period referred to in clauses
18 (ii) and (iii) of paragraph (2)(A) if applicable).

19 “(4) REQUIREMENTS OF NOTICE OF DETER-
20 MINATIONS.—The written notice of a denial of a
21 claim for benefits determination under paragraph
22 (3) shall include—

23 “(A) the reasons for the determination (in-
24 cluding a summary of the clinical or scientific-
25 evidence based rationale used in making the de-

1 termination and instruction on obtaining a
2 more complete description written in a manner
3 calculated to be understood by the average par-
4 ticipant);

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

8 “(C) notification of the right to appeal the
9 determination and instructions on how to ini-
10 tiate an appeal in accordance with subsection
11 (b).

12 “(b) INTERNAL APPEAL OF A DENIAL OF A CLAIM
13 FOR BENEFITS.—

14 “(1) RIGHT TO INTERNAL APPEAL.—

15 “(A) IN GENERAL.—A participant or bene-
16 ficiary (or authorized representative) may ap-
17 peal any denial of a claim for benefits under
18 subsection (a) under the procedures described
19 in this subsection.

20 “(B) TIME FOR APPEAL.—A group health
21 plan, and a health insurance issuer that offers
22 health insurance coverage in connection with a
23 group health plan, shall ensure that a partici-
24 pant or beneficiary (or authorized representa-
25 tive) has a period of not less than 90 days be-

1 ginning on the date of a denial of a claim for
2 benefits under subsection (a) in which to appeal
3 such denial under this subsection.

4 “(C) FAILURE TO ACT.—The failure of a
5 plan or issuer to issue a determination on a
6 claim for benefits under subsection (a) within
7 the applicable timeline established for such a
8 determination under such subsection shall be
9 treated as a denial of a claim for benefits for
10 purposes of proceeding to internal review under
11 this subsection.

12 “(D) PLAN WAIVER OF INTERNAL RE-
13 VIEW.—A group health plan, and a health in-
14 surance issuer that offers health insurance cov-
15 erage in connection with a group health plan,
16 may waive the internal review process under
17 this subsection and permit a participant or ben-
18 eficiary (or authorized representative) to pro-
19 ceed directly to external review under section
20 503B.

21 “(2) TIMELINES FOR MAKING DETERMINA-
22 TIONS.—

23 “(A) ORAL REQUESTS.—In the case of an
24 appeal of a denial of a claim for benefits under
25 this subsection that involves an expedited or

1 concurrent determination, a participant or ben-
2 eficiary (or authorized representative) may re-
3 quest such appeal orally, but a group health
4 plan, and a health insurance issuer that offers
5 health insurance coverage in connection with a
6 group health plan, may require that the partici-
7 pant or beneficiary (or authorized representa-
8 tive) provide written confirmation of such re-
9 quest in a timely manner.

10 “(B) ACCESS TO INFORMATION.—With re-
11 spect to an appeal of a denial of a claim for
12 benefits, the participant or beneficiary (or au-
13 thorized representative) and the treating health
14 care professional (if any) shall provide the plan
15 or issuer with access to information requested
16 by the plan or issuer that is necessary to make
17 a determination relating to the appeal, not later
18 than 5 days after the date on which the request
19 for the appeal is filed or to meet the applicable
20 timelines under clauses (ii) and (iii) of subpara-
21 graph (C).

22 “(C) PRIOR AUTHORIZATION DETERMINA-
23 TIONS.—

24 “(i) IN GENERAL.—A group health
25 plan, and a health insurance issuer that of-

1 fers health insurance coverage in connec-
2 tion with a group health plan, shall main-
3 tain procedures to ensure that a deter-
4 mination on an appeal of a denial of a
5 claim for benefits under this subsection is
6 made within 14 days after the date on
7 which the plan or issuer receives informa-
8 tion that is reasonably necessary to enable
9 the plan or issuer to make a determination
10 on the appeal, but in no case shall such de-
11 termination be made later than 21 days
12 after the receipt of the request for the ap-
13 peal.

14 “(ii) EXPEDITED DETERMINATION.—
15 Notwithstanding clause (i), a group health
16 plan, and a health insurance issuer that of-
17 fers health insurance coverage in connec-
18 tion with a group health plan, shall main-
19 tain procedures for expediting a prior au-
20 thorization determination on an appeal of
21 a denial of a claim for benefits described in
22 clause (i), when a request for such an ex-
23 pedited determination is made by a partici-
24 pant or beneficiary (or authorized rep-
25 resentative) at any time during the process

1 for making a determination and the treat-
2 ing health care professional substantiates,
3 with the request, that a determination
4 under the procedures described in clause
5 (i) would seriously jeopardize the life or
6 health of the participant or beneficiary.
7 Such determination shall be made not later
8 than 72 hours after the request for such
9 appeal is received by the plan or issuer
10 under this clause.

11 “(iii) CONCURRENT DETERMINA-
12 TIONS.—A group health plan, and a health
13 insurance issuer that offers health insur-
14 ance coverage in connection with a group
15 health plan, shall maintain procedures to
16 ensure that a concurrent determination on
17 an appeal of a denial of a claim for bene-
18 fits that results in a discontinuation of in-
19 patient care is made within 24 hours after
20 the receipt of the request for appeal.

21 “(B) RETROSPECTIVE DETERMINATION.—
22 A group health plan, and a health insurance
23 issuer that offers health insurance coverage in
24 connection with a group health plan, shall
25 maintain procedures to ensure that a retrospec-

1 tive determination on an appeal of a claim for
2 benefits is made within 30 days of the date on
3 which the plan or issuer receives necessary in-
4 formation that is reasonably required by the
5 plan or issuer to make a determination on the
6 appeal, but in no case shall such determination
7 be made later than 60 days after the receipt of
8 the request for the appeal.

9 “(3) CONDUCT OF REVIEW.—

10 “(A) IN GENERAL.—A review of a denial
11 of a claim for benefits under this subsection
12 shall be conducted by an individual with appro-
13 priate expertise who was not directly involved in
14 the initial determination.

15 “(B) REVIEW OF MEDICAL DETERMINA-
16 TIONS BY PHYSICIANS.—A review of an appeal
17 of a denial of a claim for benefits that is based
18 on a lack of medical necessity and appropriate-
19 ness, or based on an experimental or investiga-
20 tional treatment, or requires an evaluation of
21 medical facts, shall be made by a physician with
22 appropriate expertise, including pediatric exper-
23 tise where necessary, to evaluate the relevant
24 conditions, who was not involved in the initial
25 determination.

1 “(4) NOTICE OF DETERMINATION.—

2 “(A) IN GENERAL.—Written notice of a
3 determination made under an internal appeal of
4 a denial of a claim for benefits shall be issued
5 to the participant or beneficiary (or authorized
6 representative) and the treating health care
7 professional not later than 2 days after the
8 completion of the review (or within the 72-hour
9 or 24-hour period referred to in paragraph (2)
10 if applicable).

11 “(B) FINAL DETERMINATION.—The deter-
12 mination by a plan or issuer under this sub-
13 section shall be treated as the final determina-
14 tion of the plan or issuer on a denial of a claim
15 for benefits.

16 “(C) FAILURE TO ACT.—The failure of a
17 plan or issuer to issue a determination on an
18 appeal of a denial of a claim for benefits under
19 this subsection within the applicable timeline
20 established for such a determination shall be
21 treated as a final determination on an appeal
22 of a denial of a claim for benefits for purposes
23 of proceeding to external review under section
24 503B.

1 “(D) REQUIREMENTS OF NOTICE.—With
2 respect to a determination made under this sub-
3 section, the notice described in subparagraph
4 (A) shall include—

5 “(i) the reasons for the determination
6 (including a summary of the clinical or sci-
7 entific-evidence based rationale used in
8 making the determination and instruction
9 on obtaining a more complete description
10 written in a manner calculated to be un-
11 derstood by the average participant);

12 “(ii) the procedures for obtaining ad-
13 ditional information concerning the deter-
14 mination; and

15 “(iii) notification of the right to an
16 independent external review under section
17 503B and instructions on how to initiate
18 such a review.

19 “(c) DEFINITIONS.—The definitions contained in sec-
20 tion 503B(i) shall apply for purposes of this section.

21 **“SEC. 503B. INDEPENDENT EXTERNAL APPEALS PROCE-**
22 **DURES FOR GROUP HEALTH PLANS.**

23 “(a) RIGHT TO EXTERNAL APPEAL.—A group health
24 plan, and a health insurance issuer that offers health in-
25 surance coverage in connection with a group health plan,

1 shall provide in accordance with this section participants
2 and beneficiaries (or authorized representatives) with ac-
3 cess to an independent external review for any denial of
4 a claim for benefits.

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

7 “(1) TIME TO FILE.—A request for an inde-
8 pendent external review under this section shall be
9 filed with the plan or issuer not later than 90 days
10 after the date on which the participant or bene-
11 ficiary receives notice of the denial under section
12 503A(b)(4) or the date on which the internal review
13 is waived by the plan or issuer under section
14 503A(b)(1)(D).

15 “(2) FILING OF REQUEST.—

16 “(A) IN GENERAL.—Subject to the suc-
17 ceeding provisions of this subsection, a group
18 health plan, and a health insurance issuer that
19 offers health insurance coverage in connection
20 with a group health plan, may—

21 “(i) except as provided in subpara-
22 graph (B)(i), require that a request for re-
23 view be in writing;

1 “(ii) limit the filing of such a request
2 to the participant or beneficiary involved
3 (or an authorized representative);

4 “(iii) except if waived by the plan or
5 issuer under section 503A(b)(1)(D), condi-
6 tion access to an independent external re-
7 view under this section upon a final deter-
8 mination of a denial of a claim for benefits
9 under the internal review procedure under
10 section 503A;

11 “(iv) except as provided in subpara-
12 graph (B)(ii), require payment of a filing
13 fee to the plan or issuer of a sum that does
14 not exceed \$50; and

15 “(v) require that a request for review
16 include the consent of the participant or
17 beneficiary (or authorized representative)
18 for the release of medical information or
19 records of the participant or beneficiary to
20 the qualified external review entity for pur-
21 poses of conducting external review activi-
22 ties.

23 “(B) REQUIREMENTS AND EXCEPTION RE-
24 LATING TO GENERAL RULE.—

1 “(i) ORAL REQUESTS PERMITTED IN
2 EXPEDITED OR CONCURRENT CASES.—In
3 the case of an expedited or concurrent ex-
4 ternal review as provided for under sub-
5 section (e), the request may be made oral-
6 ly. In such case a written confirmation of
7 such request shall be made in a timely
8 manner. Such written confirmation shall be
9 treated as a consent for purposes of sub-
10 paragraph (A)(v).

11 “(ii) EXCEPTION TO FILING FEE RE-
12 QUIREMENT.—

13 “(I) INDIGENCY.—Payment of a
14 filing fee shall not be required under
15 subparagraph (A)(iv) where there is a
16 certification (in a form and manner
17 specified in guidelines established by
18 the Secretary) that the participant or
19 beneficiary is indigent (as defined in
20 such guidelines). In establishing
21 guidelines under this subclause, the
22 Secretary shall ensure that the guide-
23 lines relating to indigency are con-
24 sistent with the poverty guidelines
25 used by the Secretary of Health and

1 Human Services under title XIX of
2 the Social Security Act.

3 “(II) FEE NOT REQUIRED.—Pay-
4 ment of a filing fee shall not be re-
5 quired under subparagraph (A)(iv) if
6 the plan or issuer waives the internal
7 appeals process under section
8 503A(b)(1)(D).

9 “(III) REFUNDING OF FEE.—
10 The filing fee paid under subpara-
11 graph (A)(iv) shall be refunded if the
12 determination under the independent
13 external review is to reverse the denial
14 which is the subject of the review.

15 “(IV) INCREASE IN AMOUNT.—
16 The amount referred to in subpara-
17 graph (A)(iv) shall be increased or de-
18 creased, for each calendar year that
19 ends after December 31, 2002, by the
20 same percentage as the percentage by
21 which the Consumer Price Index for
22 All Urban Consumers (United States
23 city average), published by the Bu-
24 reau of Labor Statistics, for Sep-
25 tember of the preceding calendar year

1 has increased or decreased from the
2 such Index for September of 2002.

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

5 “(1) IN GENERAL.—Upon the filing of a re-
6 quest for independent external review with the group
7 health plan, or health insurance issuer that offers
8 health insurance coverage in connection with a group
9 health plan, the plan or issuer shall refer such re-
10 quest to a qualified external review entity selected in
11 accordance with this section.

12 “(2) ACCESS TO PLAN OR ISSUER AND HEALTH
13 PROFESSIONAL INFORMATION.—With respect to an
14 independent external review conducted under this
15 section, the participant or beneficiary (or authorized
16 representative), the plan or issuer, and the treating
17 health care professional (if any) shall provide the ex-
18 ternal review entity with access to information re-
19 quested by the external review entity that is nec-
20 essary to conduct a review under this section, as de-
21 termined by the entity, not later than 5 days after
22 the date on which a request is referred to the quali-
23 fied external review entity under paragraph (1), or
24 earlier as determined appropriate by the entity to

1 meet the applicable timelines under clauses (ii) and
2 (iii) of subsection (e)(1)(A).

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

5 “(A) IN GENERAL.—With respect to a re-
6 quest referred to a qualified external review en-
7 tity under paragraph (1) relating to a denial of
8 a claim for benefits, the entity shall refer such
9 request for the conduct of an independent med-
10 ical review unless the entity determines that—

11 “(i) any of the conditions described in
12 subsection (b)(2)(A) have not been met;

13 “(ii) the thresholds described in sub-
14 paragraph (B) have not been met;

15 “(iii) the denial of the claim for bene-
16 fits does not involve a medically reviewable
17 determination under subsection (d)(2);

18 “(iv) the denial of the claim for bene-
19 fits relates to a determination regarding
20 whether an individual is a participant or
21 beneficiary who is enrolled under the terms
22 of the plan or coverage (including the ap-
23 plicability of any waiting period under the
24 plan or coverage); or

1 “(v) the denial of the claim for bene-
2 fits is a determination as to the application
3 of cost-sharing requirements or the appli-
4 cation of a specific exclusion or express
5 limitation on the amount, duration, or
6 scope of coverage of items or services
7 under the terms and conditions of the plan
8 or coverage unless the determination is a
9 denial described in subsection (d)(2);

10 Upon making a determination that any of
11 clauses (i) through (v) applies with respect to
12 the request, the entity shall determine that the
13 denial of a claim for benefits involved is not eli-
14 gible for independent medical review under sub-
15 section (d), and shall provide notice in accord-
16 ance with subparagraph (D).

17 “(B) THRESHOLDS.—

18 “(i) IN GENERAL.—The thresholds de-
19 scribed in this subparagraph are that—

20 “(I) the total amount payable
21 under the plan or coverage for the
22 item or service that was the subject of
23 such denial exceeds \$100; or

24 “(II) a physician has asserted in
25 writing that there is a significant risk

1 of placing the life, health, or develop-
2 ment of the participant or beneficiary
3 in jeopardy if the denial of the claim
4 for benefits is sustained.

5 “(ii) THRESHOLDS NOT APPLIED.—
6 The thresholds described in this subpara-
7 graph shall not apply if the plan or issuer
8 involved waives the internal appeals proc-
9 ess with respect to the denial of a claim for
10 benefits involved under section
11 503A(b)(1)(D).

12 “(C) PROCESS FOR MAKING DETERMINA-
13 TIONS.—

14 “(i) NO DEFERENCE TO PRIOR DE-
15 TERMINATIONS.—In making determina-
16 tions under subparagraph (A), there shall
17 be no deference given to determinations
18 made by the plan or issuer under section
19 503A or the recommendation of a treating
20 health care professional (if any).

21 “(ii) USE OF APPROPRIATE PER-
22 SONNEL.—A qualified external review enti-
23 ty shall use appropriately qualified per-
24 sonnel to make determinations under this
25 section.

1 “(D) NOTICES AND GENERAL TIMELINES
2 FOR DETERMINATION.—

3 “(i) NOTICE IN CASE OF DENIAL OF
4 REFERRAL.—If the entity under this para-
5 graph does not make a referral to an inde-
6 pendent medical reviewer, the entity shall
7 provide notice to the plan or issuer, the
8 participant or beneficiary (or authorized
9 representative) filing the request, and the
10 treating health care professional (if any)
11 that the denial is not subject to inde-
12 pendent medical review. Such notice—

13 “(I) shall be written (and, in ad-
14 dition, may be provided orally) in a
15 manner calculated to be understood
16 by an average participant;

17 “(II) shall include the reasons for
18 the determination; and

19 “(III) include any relevant terms
20 and conditions of the plan or cov-
21 erage.

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

1 pendent medical reviewer, shall make a de-
2 termination within the overall timeline that
3 is applicable to the case under review as
4 described in subsection (e), except that if
5 the entity determines that a referral to an
6 independent medical reviewer 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 2 days of such determination.

11 “(d) INDEPENDENT MEDICAL REVIEW.—

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

19 “(2) MEDICALLY REVIEWABLE DETERMINA-
20 TIONS.—For purposes of this section, a denial of a
21 claim for benefits is a medically reviewable deter-
22 mination if the benefit the item or service with re-
23 spect to which the determination is made would be
24 a covered benefit under the terms and conditions of

1 the 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.—The basis of the
5 determination is that the item or service is not
6 medically necessary and appropriate.

7 “(B) DENIALS BASED ON EXPERIMENTAL
8 OR INVESTIGATIONAL TREATMENT.—The basis
9 of the determination is that the item or service
10 is experimental or investigational.

11 “(C) DENIALS OTHERWISE BASED ON AN
12 EVALUATION OF MEDICAL FACTS.—A deter-
13 mination that the item or service or condition
14 is not covered but an evaluation of the medical
15 facts by a health care professional in the spe-
16 cific case involved is necessary to determine
17 whether the item or service or condition is re-
18 quired to be provided under the terms and con-
19 ditions of the plan or coverage.

20 “(3) INDEPENDENT MEDICAL REVIEW DETER-
21 MINATION.—

22 “(A) IN GENERAL.—An independent med-
23 ical reviewer under this section shall make a
24 new independent determination with respect
25 to—

1 “(i) whether the item or service or
2 condition that is the subject of the denial
3 is covered under the terms and conditions
4 of the plan or coverage; and

5 “(ii) based upon an affirmative deter-
6 mination under clause (i), whether or not
7 the denial of a claim for a benefit that is
8 the subject of the review should be upheld
9 or reversed.

10 “(B) STANDARD FOR DETERMINATION.—

11 The independent medical reviewer’s determina-
12 tion relating to the medical necessity and ap-
13 propriateness, or the experimental or investiga-
14 tion nature, or the evaluation of the medical
15 facts of the item, service, or condition shall be
16 based on the medical condition of the partici-
17 pant or beneficiary (including the medical
18 records of the participant or beneficiary) and
19 the valid, relevant scientific evidence and clin-
20 ical evidence. The independent medical reviewer
21 may consider peer-reviewed medical literature
22 or findings and peer-reviewed expert opinions
23 and expert consensus. In determining the med-
24 ical necessity and appropriateness of any item
25 or service for which a claim for benefits is de-

1 nied, the independent medical reviewer shall
2 consider the effectiveness of the alternative
3 items and services, if any, for which benefits
4 were authorized by the plan or issuer involved
5 for the participant or beneficiary.

6 “(C) NO COVERAGE FOR EXCLUDED BENE-
7 FITS.—Nothing in this subsection shall be con-
8 strued to permit an independent medical re-
9 viewer to require that a group health plan, or
10 health insurance issuer that offers health insur-
11 ance coverage in connection with a group health
12 plan, provide coverage for items or services that
13 are specifically excluded or expressly limited
14 under the plan or coverage and that are not
15 covered regardless of any determination relating
16 to medical necessity and appropriateness, exper-
17 imental or investigational nature of the treat-
18 ment, or an evaluation of the medical facts in
19 the case involved.

20 “(D) EVIDENCE AND INFORMATION TO BE
21 USED IN MEDICAL REVIEWS.—In making a de-
22 termination under this subsection, the inde-
23 pendent medical reviewer shall also consider ap-
24 propriate and available evidence and informa-
25 tion, including the following:

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

6 “(ii) The recommendation of the
7 treating health care professional and the
8 evidence, guidelines, and rationale used by
9 the treating health care professional in
10 reaching such recommendation.

11 “(iii) Additional evidence or informa-
12 tion obtained by the reviewer or submitted
13 by the plan, issuer, participant or bene-
14 ficiary (or an authorized representative), or
15 treating health care professional.

16 “(iv) The plan or coverage document.

17 “(E) INDEPENDENT DETERMINATION.—In
18 making the determination, the independent
19 medical reviewer shall—

20 “(i) consider the claim under review
21 without deference to the determinations
22 made by the plan or issuer under section
23 503A or the recommendation of the treat-
24 ing health care professional (if any); and

1 “(ii) consider, but not be bound by
2 the definition used by the plan or issuer of
3 ‘medically necessary and appropriate’, or
4 ‘experimental or investigational’, or other
5 equivalent terms that are used by the plan
6 or issuer to describe medical necessity and
7 appropriateness or experimental or inves-
8 tigational nature of the treatment.

9 “(F) DETERMINATION OF INDEPENDENT
10 MEDICAL REVIEWER.—An independent medical
11 reviewer shall, in accordance with the deadlines
12 described in subsection (e), prepare a written
13 determination to uphold or reverse the denial
14 under review and, in the case of a reversal, the
15 timeframe within which the plan or issuer shall
16 authorize coverage to comply with the deter-
17 mination. Such written determination shall in-
18 clude the specific reasons of the reviewer for
19 such determination, including a summary of the
20 clinical or scientific-evidence based rationale
21 used in making the determination. The reviewer
22 may provide the plan or issuer and the treating
23 health care professional with additional rec-
24 ommendations in connection with such a deter-
25 mination, but any such recommendations shall

1 not be treated as part of the determination and
2 shall not be admissible in any action under sec-
3 tion 502.

4 “(e) TIMELINES AND NOTIFICATIONS.—

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

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

9 “(i) IN GENERAL.—The independent
10 medical reviewer (or reviewers) shall make
11 a determination on a denial of a claim for
12 benefits that is referred to the reviewer
13 under subsection (c)(3) not later than 14
14 days after the receipt of information under
15 subsection (c)(2) if the review involves a
16 prior authorization of items or services.

17 “(ii) EXPEDITED DETERMINATION.—
18 Notwithstanding clause (i), the inde-
19 pendent medical reviewer (or reviewers)
20 shall make an expedited determination on
21 a denial of a claim for benefits described in
22 clause (i), when a request for such an ex-
23 pedited determination is made by a partici-
24 pant or beneficiary (or authorized rep-
25 resentative) at any time during the process

1 for making a determination, and the treat-
2 ing health care professional substantiates,
3 with the request, that a determination
4 under the timeline described in clause (i)
5 would seriously jeopardize the life or health
6 of the participant or beneficiary. Such de-
7 termination shall be made not later than
8 72 hours after the receipt of information
9 under subsection (c)(2).

10 “(iii) CONCURRENT DETERMINA-
11 TION.—Notwithstanding clause (i), a re-
12 view described in such subclause shall be
13 completed not later than 24 hours after
14 the receipt of information under subsection
15 (c)(2) if the review involves a discontinu-
16 ation of inpatient care.

17 “(B) RETROSPECTIVE DETERMINATION.—
18 The independent medical reviewer (or review-
19 ers) shall complete a review in the case of a ret-
20 rospective determination on an appeal of a de-
21 nial of a claim for benefits that is referred to
22 the reviewer under subsection (c)(3) not later
23 than 30 days after the receipt of information
24 under subsection (c)(2).

1 “(2) NOTIFICATION OF DETERMINATION.—The
2 external review entity shall ensure that the plan or
3 issuer, the participant or beneficiary (or authorized
4 representative) and the treating health care profes-
5 sional (if any) receives a copy of the written deter-
6 mination of the independent medical reviewer pre-
7 pared under subsection (d)(3)(F). Nothing in this
8 paragraph shall be construed as preventing an entity
9 or reviewer from providing an initial oral notice of
10 the reviewer’s determination.

11 “(3) FORM OF NOTICES.—Determinations and
12 notices under this subsection shall be written in a
13 manner calculated to be understood by an average
14 participant.

15 “(4) TERMINATION OF EXTERNAL REVIEW
16 PROCESS IF APPROVAL OF A CLAIM FOR BENEFITS
17 DURING PROCESS.—

18 “(A) IN GENERAL.—If a plan or issuer—

19 “(i) reverses a determination on a de-
20 nial of a claim for benefits that is the sub-
21 ject of an external review under this sec-
22 tion and authorizes coverage for the claim
23 or provides payment of the claim; and

24 “(ii) provides notice of such reversal
25 to the participant or beneficiary (or au-

1 thorized representative) and the treating
2 health care professional (if any), and the
3 external review entity responsible for such
4 review,

5 the external review process shall be terminated
6 with respect to such denial and any filing fee
7 paid under subsection (b)(2)(A)(iv) shall be re-
8 funded.

9 “(B) TREATMENT OF TERMINATION.—An
10 authorization of coverage under subparagraph
11 (A) by the plan or issuer shall be treated as a
12 written determination to reverse a denial under
13 section (d)(3)(F) for purposes of liability under
14 section 502(n)(1)(B).

15 “(f) COMPLIANCE.—

16 “(1) APPLICATION OF DETERMINATIONS.—

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

22 “(B) COMPLIANCE WITH DETERMINA-
23 TION.—If the determination of an independent
24 medical reviewer is to reverse the denial, the
25 plan or issuer, upon the receipt of such deter-

1 mination, shall authorize coverage to comply
2 with the medical reviewer’s determination in ac-
3 cordance with the timeframe established by the
4 medical reviewer under subsection (d)(3)(F).

5 “(2) FAILURE TO COMPLY.—

6 “(A) WITH TIMEFRAME FOR PROVIDING
7 ITEMS AND SERVICES.—If a plan or issuer fails
8 to comply with the timeframe established under
9 paragraph (1)(B) with respect to a participant
10 or beneficiary, where such failure to comply is
11 caused by the plan or issuer, the participant or
12 beneficiary may obtain the items or services in-
13 volved (in a manner consistent with the deter-
14 mination of the independent external reviewer)
15 from any provider regardless of whether such
16 provider is a participating provider under the
17 plan or coverage.

18 “(B) REIMBURSEMENT.—

19 “(i) IN GENERAL.—Where a partici-
20 pant or beneficiary obtains items or serv-
21 ices in accordance with subparagraph (A),
22 the plan or issuer involved shall provide for
23 reimbursement of the costs of such items
24 or services. Such reimbursement shall be
25 made to the treating health care profes-

1 sional or to the participant or beneficiary
2 (in the case of a participant or beneficiary
3 who pays for the costs of such items or
4 services).

5 “(ii) AMOUNT.—The plan or issuer
6 shall fully reimburse a professional, partici-
7 pant or beneficiary under clause (i) for the
8 total costs of the items or services provided
9 (regardless of any plan limitations that
10 may apply to the coverage of such items or
11 services) so long as—

12 “(I) the items or services would
13 have been covered under the terms of
14 the plan or coverage if provided by the
15 plan or issuer; and

16 “(II) the items or services were
17 provided in a manner consistent with
18 the determination of the independent
19 medical reviewer.

20 “(C) FAILURE TO REIMBURSE.—Where a
21 plan or issuer fails to provide reimbursement to
22 a professional, participant or beneficiary in ac-
23 cordance with this paragraph, the professional,
24 participant or beneficiary may commence a civil
25 action (or utilize other remedies available under

1 law) to recover only the amount of any such re-
2 imbursement that is unpaid and any necessary
3 legal costs or expenses (including attorneys'
4 fees) incurred in recovering such reimburse-
5 ment.

6 “(g) QUALIFICATIONS OF INDEPENDENT MEDICAL
7 REVIEWERS.—

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

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

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

18 “(C) compensation provided by the entity
19 to the reviewer is consistent with paragraph
20 (6).

21 “(2) LICENSURE AND EXPERTISE.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), each independent medical reviewer
24 shall be a physician (who is an allopathic or os-

1 teopathic physician) or health care professional
2 who—

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

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

9 “(B) PHYSICIAN REVIEW.—In referring a
10 denial for independent medical review under
11 subsection (c), the qualified external review en-
12 tity shall ensure that, in the case of the review
13 of treatment that is recommended or provided
14 by a physician, such referral may be made only
15 to a physician for such independent medical re-
16 view.

17 “(3) INDEPENDENCE.—

18 “(A) IN GENERAL.—Subject to subpara-
19 graph (B), each independent medical reviewer
20 in a case shall—

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

23 “(ii) not have a material familial, fi-
24 nancial, or professional relationship with
25 such a party; and

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

4 “(B) EXCEPTION.—Nothing in this sub-
5 paragraph (A) shall be construed to—

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

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

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

15 “(III) the fact of such an affilia-
16 tion is disclosed to the plan or issuer
17 and the participant or beneficiary (or
18 authorized representative) and neither
19 party objects; and

20 “(IV) the affiliated individual is
21 not an employee of the plan or issuer
22 and does not provide services exclu-
23 sively or primarily to or on behalf of
24 the plan or issuer;

1 “(ii) prohibit an individual who has
2 staff privileges at the institution where the
3 treatment involved takes place from serv-
4 ing as an independent medical reviewer if
5 the affiliation is disclosed to the plan or
6 issuer and the participant or beneficiary
7 (or authorized representative), and neither
8 party objects; or

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

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

15 “(A) IN GENERAL.—The requirement of
16 this paragraph with respect to a reviewer in a
17 case involving treatment, or the provision of
18 items or services, by—

19 “(i) a physician, is that the reviewer
20 be a practicing physician of the same or
21 similar specialty as a physician who typi-
22 cally treats the diagnosis or condition or
23 provides such treatment in the case under
24 review; or

1 “(ii) a health care professional (other
2 than a physician), is that the reviewer be
3 a practicing physician or, if determined ap-
4 propriate by the qualified external review
5 entity, a health care professional (other
6 than a physician), of the same or similar
7 specialty as the health care professional
8 who typically treats the diagnosis or condi-
9 tion or provides the treatment in the case
10 under review.

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

18 “(5) PEDIATRIC EXPERTISE.—The independent
19 medical reviewer shall have pediatric expertise under
20 paragraph (2) where necessary to evaluate the rel-
21 evant conditions for the participant or beneficiary
22 involved.

23 “(6) LIMITATIONS ON REVIEWER COMPENSA-
24 TION.—Compensation provided by a qualified exter-
25 nal review entity to an independent medical reviewer

1 in connection with a review under this section
2 shall—

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

4 “(B) not be contingent on the determina-
5 tion rendered by the reviewer.

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

11 “(A) The plan, plan sponsor, or issuer in-
12 volved, or any fiduciary, officer, director, or em-
13 ployee of such plan, plan sponsor, or issuer.

14 “(B) The participant or beneficiary (or au-
15 thorized representative).

16 “(C) The health care professional that pro-
17 vides the items of services involved in the de-
18 nial.

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

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

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

4 “(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

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

7 “(A) LIMITATION ON PLAN OR ISSUER SE-
8 LECTION.—The Secretary shall implement pro-
9 cedures with respect to the selection of qualified
10 external review entities by a plan or issuer to
11 assure that the selection process among quali-
12 fied external review entities will not create any
13 incentives for external review entities to make a
14 determination in a biased manner. No such se-
15 lection process under the procedures imple-
16 mented by the Secretary may give either the pa-
17 tient or the plan or issuer any ability to deter-
18 mine or influence the selection of a qualified ex-
19 ternal review entity to review the case of any
20 participant or beneficiary.

21 “(B) STATE AUTHORITY WITH RESPECT
22 TO QUALIFIED EXTERNAL REVIEW ENTITIES
23 FOR HEALTH INSURANCE ISSUERS.—With re-
24 spect to health insurance issuers offering health
25 insurance coverage in a State, the State may

1 provide for the designation or selection of quali-
2 fied external review entities in a manner deter-
3 mined by the State to assure an unbiased deter-
4 mination in conducting external review activi-
5 ties. In conducting reviews under this section,
6 an entity designated or selected under this sub-
7 paragraph shall comply with provisions of this
8 section.

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

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

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

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

1 Subparagraph (B) shall not be construed as apply-
2 ing to the imposition of a filing fee under subsection
3 (b)(2)(A)(iv) or costs incurred by the participant or
4 beneficiary (or authorized representative) or treating
5 health care professional (if any) in support of the re-
6 view, including the provision of additional evidence
7 or information.

8 “(4) QUALIFICATIONS.—

9 “(A) IN GENERAL.—In this section, the
10 term ‘qualified external review entity’ means, in
11 relation to a plan or issuer, an entity that is
12 initially certified (and periodically recertified)
13 under subparagraph (C) as meeting the fol-
14 lowing requirements:

15 “(i) The entity has (directly or
16 through contracts or other arrangements)
17 sufficient medical, legal, and other exper-
18 tise and sufficient staffing to carry out du-
19 ties of a qualified external review entity
20 under this section on a timely basis, in-
21 cluding making determinations under sub-
22 section (b)(2)(A) and providing for inde-
23 pendent medical reviews under subsection
24 (d).

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

6 “(iii) The entity has provided assur-
7 ances that it will conduct external review
8 activities consistent with the applicable re-
9 quirements of this section and standards
10 specified in subparagraph (C), including
11 that it will not conduct any external review
12 activities in a case unless the independence
13 requirements of subparagraph (B) are met
14 with respect to the case.

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

18 “(v) The entity meets such other re-
19 quirements as the Secretary provides by
20 regulation.

21 “(B) INDEPENDENCE REQUIREMENTS.—

22 “(i) IN GENERAL.—Subject to clause
23 (ii), an entity meets the independence re-
24 quirements of this subparagraph with re-
25 spect to any case if the entity—

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

3 “(II) does not have a material fa-
4 milial, financial, or professional rela-
5 tionship with such a party; and

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

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

17 “(iii) LIMITATIONS ON ENTITY COM-
18 PENSATION.—Compensation provided by a
19 plan or issuer to, or charged by, a qualified
20 external review entity in connection with
21 reviews under this section shall—

22 “(I) not exceed a reasonable
23 level; and

24 “(II) not be contingent on the
25 determination rendered by the entity

1 or by any independent medical re-
2 viewer.

3 “(C) CERTIFICATION AND RECERTIFI-
4 CATION PROCESS.—

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

8 “(I) under a process that is rec-
9 ognized or approved by the Secretary;
10 or

11 “(II) by a qualified private
12 standard-setting organization that is
13 approved by the Secretary under
14 clause (iii).

15 The Secretary shall promulgate regulations
16 setting forth the process described in sub-
17 clause (I).

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

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

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

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

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

14 “(IV) in the case of recertifi-
15 cation, shall review the matters de-
16 scribed in clause (iv).

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

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

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

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

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

18 “(III) Compliance with limita-
19 tions on compensation (with respect to
20 both the entity and independent med-
21 ical reviewers it refers cases to).

22 “(IV) Compliance with applicable
23 independence requirements.

24 “(V) Quality and consistency of
25 medical review determinations with

1 valid, relevant scientific and clinical
2 evidence, as provided under clause
3 (vii).

4 “(v) PERIOD OF CERTIFICATION OR
5 RECERTIFICATION.—A certification or re-
6 certification provided under this paragraph
7 shall extend for a period not to exceed 3
8 years.

9 “(vi) REVOCATION.—A certification or
10 recertification under this paragraph may
11 be revoked by the Secretary or by the or-
12 ganization providing such certification
13 upon a showing of cause.

14 “(vii) ASSURANCE OF QUALITY AND
15 CONSISTENCY WITH VALID, RELEVANT SCI-
16 ENTIFIC AND CLINICAL EVIDENCE OF EX-
17 TERNAL REVIEW DETERMINATIONS.—The
18 standards applied under this subparagraph
19 shall include procedures, promulgated by
20 the Secretary in consultation with the Sec-
21 retary of Health and Human Services, to
22 assure that each qualified external review
23 entity is accountable for the quality and
24 consistency of the external review deter-
25 minations made by its independent medical

1 reviewers with valid, relevant scientific and
2 clinical evidence.

3 “(D) PROVISION OF INFORMATION.—

4 “(i) IN GENERAL.—A qualified exter-
5 nal review entity shall provide to the Sec-
6 retary, in such manner and at such times
7 as the Secretary may require, such infor-
8 mation (relating to the denials which have
9 been referred to the entity for the conduct
10 of external review under this section) as
11 the Secretary determines appropriate to
12 assure compliance with the independence
13 and other requirements of this section to
14 monitor and assess the quality of its exter-
15 nal review activities and lack of bias in
16 making determinations. Such information
17 shall include information described in
18 clause (ii) but shall not include individually
19 identifiable medical information.

20 “(ii) INFORMATION TO BE IN-
21 CLUDED.—The information described in
22 this subclause with respect to an entity is
23 as follows:

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

4 “(II) The disposition by the enti-
5 ty of such denials, including the num-
6 ber referred to a independent medical
7 reviewer and the reasons for such dis-
8 positions (including the application of
9 exclusions), on a plan or issuer-spe-
10 cific basis and on a health care spe-
11 cialty-specific basis.

12 “(III) The length of time in mak-
13 ing determinations with respect to
14 such denials.

15 “(IV) Updated information on
16 the information required to be sub-
17 mitted as a condition of certification
18 with respect to the entity’s perform-
19 ance of external review activities.

20 “(iii) INFORMATION TO BE PROVIDED
21 TO CERTIFYING ORGANIZATION.—

22 “(I) IN GENERAL.—In the case
23 of a qualified external review entity
24 which is certified (or recertified)
25 under this subsection by a qualified

1 private standard-setting organization,
2 at the request of the organization, the
3 entity shall provide the organization
4 with the information provided to the
5 Secretary under clause (i).

6 “(II) ADDITIONAL INFORMA-
7 TION.—Nothing in this subparagraph
8 shall be construed as preventing such
9 an organization from requiring addi-
10 tional information as a condition of
11 certification or recertification of an
12 entity.

13 “(iv) USE OF INFORMATION.—

14 “(I) IN GENERAL.—Information
15 provided under this subparagraph
16 may be used by the Secretary and
17 qualified private standard-setting or-
18 ganizations to conduct oversight of
19 qualified external review entities, in-
20 cluding recertification of such entities,
21 and shall be made available to the
22 public in an appropriate manner.

23 “(II) REPORT TO CONGRESS.—
24 Not later than 2 years after the date
25 on which the Patients’ Bill of Rights

1 Act of 2001 takes effect under section
2 501 of such Act, and every 2 years
3 thereafter, the Secretary, in consulta-
4 tion with the Secretary of Health and
5 Human Services, shall prepare and
6 submit to the appropriate committees
7 of Congress, a report that contains—

8 “(aa) a summary of the in-
9 formation provided to the Sec-
10 retary under clause (ii);

11 “(bb) a description of the ef-
12 fect that the appeals process es-
13 tablished under this section and
14 section 503A had on the access
15 of individuals to health insurance
16 and health care;

17 “(cc) a description of the ef-
18 fect on health care costs associ-
19 ated with the implementation of
20 the appeals process described in
21 item (bb); and

22 “(dd) a description of the
23 quality and consistency of deter-
24 minations by qualified external
25 review entities.

1 “(III) RECOMMENDATIONS.—The
2 Secretary may from time to time sub-
3 mit recommendations to Congress
4 with respect to proposed modifications
5 to the appeals process based on the
6 reports submitted under subclause
7 (II).

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

21 “(i) DEFINITIONS AND RELATED RULES.—For pur-
22 poses of this section—

23 “(1) AUTHORIZED REPRESENTATIVE.—The
24 term ‘authorized representative’ means, with respect
25 to a participant or beneficiary—

1 “(A) a person to whom a participant or
2 beneficiary has given express written consent to
3 represent the participant or beneficiary in any
4 proceeding under this section;

5 “(B) a person authorized by law to provide
6 substituted consent for the participant or bene-
7 ficiary; or

8 “(C) a family member of the participant or
9 beneficiary (or the estate of the participant or
10 beneficiary) or the participant’s or beneficiary’s
11 treating health care professional when the par-
12 ticipant or beneficiary is unable to provide con-
13 sent.

14 “(2) CLAIM FOR BENEFITS.—The term ‘claim
15 for benefits’ means any request by a participant or
16 beneficiary (or authorized representative) for bene-
17 fits, for eligibility, or for payment in whole or in
18 part, for an item or service under a group health
19 plan or health insurance coverage offered by a
20 health insurance issuer in connection with a group
21 health plan.

22 “(3) GROUP HEALTH PLAN.—The term ‘group
23 health plan’ shall have the meaning given such term
24 in section 733(a).

1 “(4) HEALTH INSURANCE COVERAGE.—The
2 term ‘health insurance coverage’ has the meaning
3 given such term in section 733(b)(1).

4 “(5) HEALTH INSURANCE ISSUER.—The term
5 ‘health insurance issuer’ has the meaning given such
6 term in section 733(b)(2).

7 “(6) PRIOR AUTHORIZATION DETERMINA-
8 TION.—The term ‘prior authorization determination’
9 means a determination by the group health plan or
10 health insurance issuer offering health insurance
11 coverage in connection with a group health plan
12 prior to the provision of the items and services as
13 a condition of coverage of the items and services
14 under the terms and conditions of the plan or cov-
15 erage.

16 “(7) TREATING HEALTH CARE PROFES-
17 SIONAL.—The term ‘treating health care profes-
18 sional’ with respect to a group health plan, health
19 insurance issuer or provider sponsored organization
20 means a physician (medical doctor or doctor of oste-
21 opathy) or other health care practitioner who is act-
22 ing within the scope of his or her State licensure or
23 certification for the delivery of health care services
24 and who is primarily responsible for delivering those
25 services to the participant or beneficiary.

1 “(8) UTILIZATION REVIEW.—The term ‘utiliza-
2 tion review’ with respect to a group health plan or
3 health insurance coverage means procedures used in
4 the determination of coverage for a participant or
5 beneficiary, such as procedures to evaluate the med-
6 ical necessity, appropriateness, efficacy, quality, or
7 efficiency of health care services, procedures or set-
8 tings, and includes prospective review, concurrent re-
9 view, second opinions, case management, discharge
10 planning, or retrospective review.

11 “(9) TREATMENT OF EXCEPTED BENEFITS.—
12 The requirements of this section and section 503A
13 shall not apply to excepted benefits (as defined in
14 section 733(c)), other than benefits described in sec-
15 tion 733(c)(2)(A), in the same manner as the provi-
16 sions of part 7 do not apply to such benefits under
17 subsections (b) and (c) of section 732.”.

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. Claims and internal appeals procedures for group health plans.

“Sec. 503B. Independent external appeals procedures for group health plans.”.

1 **SEC. 132. ENFORCEMENT.**

2 (a) CIVIL PENALTY AUTHORITY.—Section 502(c) of
3 the Employee Retirement Income Security Act of 1974
4 (29 U.S.C. 1132(c)) is amended—

5 (1) by redesignating paragraph (7) as para-
6 graph (8); and

7 (2) by inserting after paragraph (6) the fol-
8 lowing new paragraph: in subsection (a)(1)(A), by
9 inserting “or (n)” after “subsection (c)”; and
10 “(7)(A) In the case of—

11 “(i) a failure described in section 503B(f)(2)(A)
12 (relating to failure to comply with timeframe for
13 providing items and services), or

14 “(ii) a failure of a group health plan or health
15 insurance issuer to take such actions as are nec-
16 essary to refer a denial of a claim for benefit to
17 independent medical review in accordance with sec-
18 tion 503B(c)(1) or to provide information required
19 in connection with such a referral under section
20 503B(c)(2),

21 the Secretary may assess a civil penalty in an amount de-
22 termined under subparagraph (B) against any person who,
23 acting in the capacity of authorizing the benefit involved,
24 causes such failure.

25 “(B)(i) Subject to clause (iii), such civil penalty shall
26 not exceed the amount specified in clause (ii) for each day

1 from the date of commencement of such failure until the
2 date the failure is corrected.

3 “(ii) The amount specified in this clause for any day
4 described in clause (i) shall be—

5 “(I) \$2,000 a day for the 1st through the 7th
6 days,

7 “(II) \$5,000 a day for the 8th through the 14th
8 days, and

9 “(III) \$10,000 a day for each day after the
10 14th day.

11 “(iii) The total amount of the penalty under clause
12 (i) may not exceed \$500,000.

13 “(C) Civil monetary penalties under the preceding
14 provisions of this paragraph may be imposed against au-
15 thorized officials for failure to provide referral to a quali-
16 fied external review entity or access to health information,
17 as required under section 503B(c)(1) and (2).

18 “(D)(i) In addition to any penalty imposed under
19 subparagraph (A), the Secretary may assess a civil penalty
20 against a person acting in the capacity of authorizing a
21 benefit determined by an external review entity for one
22 or more group health plans, or health insurance issuers
23 offering health insurance coverage, for any pattern or
24 practice of repeated violations of the requirements of this
25 section with respect to such plan or coverage (including

1 any failure described in subparagraph (A)(i) or the refusal
2 to authorize a benefit determined by an external appeal
3 entity to be covered).

4 “(ii) Such penalty shall be payable only upon proof
5 by clear and convincing evidence of such pattern or prac-
6 tice and shall be in an amount not to exceed for such pat-
7 tern or practice the lesser of—

8 “(I) 25 percent of the aggregate value of bene-
9 fits shown by the Secretary to have not been pro-
10 vided, or unlawfully delayed, in violation of this sec-
11 tion under such pattern or practice; or

12 “(II) \$500,000.

13 “(iii) Any person acting in the capacity of authorizing
14 benefits who has engaged in any such pattern or practice
15 described in clause (i) with respect to a plan or coverage,
16 upon the petition of the Secretary, may be removed by
17 the court from such position, and from any other involve-
18 ment, with respect to such a plan or coverage, and may
19 be precluded from returning to any such position or in-
20 volvement for a period determined by the court.

21 “(E) In any action under this paragraph to collect
22 a civil penalty under subparagraph (A) or (D), the court
23 shall cause to be served on the defendant an order requir-
24 ing the defendant—

1 “(i) to cease and desist from the alleged failure
2 to act; and

3 “(ii) to pay to the Secretary a reasonable attor-
4 ney’s fee and other reasonable costs relating to the
5 prosecution of the action on the charges on which
6 the Secretary prevails.

7 “(F) The preceding provisions of this paragraph shall
8 not apply with respect to employee benefit plans that are
9 not group health plans. Such provisions also shall not
10 apply to excepted benefits (as defined in section 733(c)),
11 other than benefits described in section 733(c)(2)(A), in
12 the same manner as the provisions of part 7 do not apply
13 to such benefits under subsections (b) and (c) of section
14 732.

15 “(G) The remedies provided under this paragraph are
16 in addition to any other available remedies.”.

17 (b) CONFORMING AMENDMENT.—Section 502(a)(6)
18 of such Act (29 U.S.C. 1132(a)(6)) is amended by striking
19 “or (6)” and inserting “(6), or (7)”.

20 **Subtitle D—Remedies**

21 **SEC. 141. AVAILABILITY OF COURT REMEDIES.**

22 (a) IN GENERAL.—Section 502 of the Employee Re-
23 tirement Income Security Act of 1974 (29 U.S.C. 1132)
24 is amended by adding at the end the following:

1 “(n) CAUSE OF ACTION RELATING TO DENIAL OF A
2 CLAIM FOR HEALTH BENEFITS.—

3 “(1) IN GENERAL.—

4 “(A) FAILURE TO COMPLY WITH EXTER-
5 NAL MEDICAL REVIEW.—With respect to an ac-
6 tion commenced by a participant or beneficiary
7 (or the estate of the participant or beneficiary)
8 in connection with a claim for benefits under a
9 group health plan, if—

10 “(i) a designated decisionmaker de-
11 scribed in paragraph (2) fails to exercise
12 ordinary care in failing to authorize cov-
13 erage in compliance with the written deter-
14 mination of an independent medical re-
15 viewer under section 503B(d)(3)(F) that
16 reverses a denial of the claim for benefits;
17 and

18 “(ii) the failure described in clause (i)
19 is the proximate cause of substantial harm
20 (as defined in paragraph (14)(G)) to the
21 participant or beneficiary;

22 such designated decisionmaker shall be liable to
23 the participant or beneficiary (or the estate) for
24 economic and noneconomic damages in connec-

1 tion with such failure and such injury or death
2 (subject to paragraph (4)).

3 “(B) WRONGFUL DETERMINATION RE-
4 SULTING IN DELAY IN PROVIDING OR FAILURE
5 TO RECEIVE BENEFITS.—With respect to an ac-
6 tion commenced by a participant or beneficiary
7 (or the estate of the participant or beneficiary)
8 in connection with a claim for benefits under a
9 group health plan, if—

10 “(i) a designated decisionmaker de-
11 scribed in paragraph (2)—

12 “(I) fails to exercise ordinary
13 care in making a determination deny-
14 ing the claim for benefits under sec-
15 tion 503A(a) (relating to an initial
16 claim for benefits); or

17 “(II) fails to exercise ordinary
18 care in making a determination deny-
19 ing the claim for benefits under sec-
20 tion 503A(b) (relating to an internal
21 appeal);

22 “(ii) the denial described in clause
23 (i)—

1 “(I) is reversed by an inde-
2 pendent medical reviewer under sec-
3 tion 503B(d) or 503B(e)(4)(B), or

4 “(II) was determined by a quali-
5 fied external review entity under sec-
6 tion 503B(e)(3) not to be eligible for
7 referral for independent medical re-
8 view under such section; and

9 “(iii) the delay in receiving, or failure
10 to receive, benefits attributable to the fail-
11 ure described in clause (i) is the proximate
12 cause of substantial harm to, or the wrong-
13 ful death of, the participant or beneficiary;
14 such designated decisionmaker shall be liable to
15 the participant or beneficiary (or the estate) for
16 economic and noneconomic damages in connec-
17 tion with such failure and such injury or death
18 (subject to paragraph (4)).

19 “(C) LIMITATION ON LIABILITY BASED ON
20 APPOINTMENT OF DESIGNATED DECISION-
21 MAKER.—If a plan sponsor or named fiduciary
22 appoints a designated decisionmaker in accord-
23 ance with paragraph (2), the plan sponsor or
24 named fiduciary, or any other person or group
25 health plan (or their employees) associated with

1 the plan sponsor or named fiduciary, shall not
2 be liable under this paragraph. The appoint-
3 ment of a designated decisionmaker in accord-
4 ance with paragraph (2) shall not affect the li-
5 ability of the appointing plan sponsor or named
6 fiduciary for the failure of the plan sponsor or
7 named fiduciary to comply with any other re-
8 quirement of this title.

9 “(2) DESIGNATED DECISIONMAKER.—

10 “(A) APPOINTMENT.—

11 “(i) IN GENERAL.—The plan sponsor
12 or named fiduciary of a group health plan
13 shall, in accordance with this paragraph,
14 designate one or more persons to serve as
15 a designated decisionmaker with respect to
16 causes of action described in subpara-
17 graphs (A) and (B) of paragraph (1), ex-
18 cept that—

19 “(I) with respect to health insur-
20 ance coverage offered in connection
21 with a group health plan, the health
22 insurance issuer shall be the des-
23 ignated decisionmaker unless the plan
24 sponsor and the issuer specifically
25 agree in writing (on a form to be pre-

1 scribed by the Secretary) to substitute
2 another person as the designated deci-
3 sionmaker; or

4 “**(II)** with respect to the designa-
5 tion of a person other than a plan
6 sponsor or health insurance issuer,
7 such person shall satisfy the require-
8 ments of subparagraph (D).

9 “**(ii) PLAN DOCUMENTS.**—The des-
10 ignated decisionmaker shall be specifically
11 designated as such in the written instru-
12 ments of the plan (under section 402(a))
13 and be identified as required under section
14 121(b)(14) of the Patients’ Bill of Rights
15 Act of 2001.

16 “**(B) AUTHORITY.**—A designated decision-
17 maker appointed under subparagraph (A) shall
18 have the exclusive authority under the group
19 health plan—

20 “(i) to make determinations with re-
21 spect to a claim for benefits under section
22 503A(a) (relating to an initial claim for
23 benefits);

1 “(ii) to make final determinations
2 under section 503A(b) (relating to an in-
3 ternal appeal); or

4 “(iii) to approve coverage pursuant to
5 the written determination of independent
6 medical reviewers under section 503B.

7 “(C) ALLOCATION OF RESPONSIBILITY.—
8 Responsibility may be allocated among different
9 designated decisionmakers with respect to—

10 “(i) for purposes of paragraph (1)(A),
11 the approval of coverage under section
12 503B;

13 “(ii) for purposes of paragraph
14 (1)(B), making determinations on a claim
15 for benefits under section 503A(a) (relat-
16 ing to an initial claim for benefits); and

17 “(iii) for purposes of paragraph
18 (1)(B), making final determinations on
19 claims for benefits under section 503A(b)
20 (relating to internal appeals).

21 Where such an allocation is made, liability
22 under a cause of action under paragraph (1)
23 shall be assessed against the appropriate des-
24 ignated decisionmaker.

25 “(D) QUALIFICATIONS.—

1 “(i) CERTIFICATION OF ABILITY.—To
2 be appointed as a designated decision-
3 maker under this paragraph, a person shall
4 provide to the plan sponsor or named fidu-
5 ciary a certification of such person’s ability
6 to meet the requirement of clause (ii) and
7 the requirements of clause (iii) (relating to
8 financial obligation for liability under this
9 subsection). Such certification shall be pro-
10 vided upon appointment and not less fre-
11 quently than annually thereafter, or if the
12 designation is pursuant to a multi-year
13 contract, in conjunction with the renewal
14 of the contract, but in no case less than
15 once every 3 years.

16 “(ii) TREATING PHYSICIAN NOT ELI-
17 GIBLE.—The treating physician of a par-
18 ticipant or beneficiary is not qualified to be
19 appointed as a designated decisionmaker
20 under this paragraph with respect to
21 claims for benefits of such participant or
22 beneficiary relating to the services of that
23 physician.

24 “(iii) OTHER REQUIREMENTS RELAT-
25 ING TO FINANCIAL OBLIGATIONS.—For

1 purposes of clause (i), requirements relat-
2 ing to financial obligation for liability shall
3 include evidence of—

4 “(I) coverage of the person under
5 insurance policies or other arrange-
6 ments, secured and maintained by the
7 person, to insure the person against
8 losses arising from professional liabil-
9 ity claims, including those arising
10 from being designated as a designated
11 decisionmaker under this paragraph;
12 or

13 “(II) minimum capital and sur-
14 plus levels that are maintained by the
15 person to cover any losses as a result
16 of liability arising from being des-
17 ignated as a designated decisionmaker
18 under this paragraph.

19 The appropriate amounts of liability insur-
20 ance and minimum capital and surplus lev-
21 els for purposes of subclauses (I) and (II)
22 shall be determined by an actuary using
23 sound actuarial principles and accounting
24 practices pursuant to established guidelines
25 of the American Academy of Actuaries and

1 shall be maintained throughout the course
2 of the contract in which such person is
3 designated as a designated decisionmaker.

4 “(E) FLEXIBILITY IN ADMINISTRATION.—

5 A group health plan, and a health insurance
6 issuer offering health insurance coverage in
7 connection with a group health plan, may
8 provide—

9 “(i) that any person or group of per-
10 sons may serve in more than one capacity
11 with respect to the plan or coverage (in-
12 cluding service as a designated decision-
13 maker, administrator, and named fidu-
14 ciary); or

15 “(ii) that a designated decisionmaker
16 may employ one or more persons to pro-
17 vide advice with respect to any responsi-
18 bility of such decisionmaker under the plan
19 or coverage.

20 “(F) FAILURE TO APPOINT.—With respect
21 to any cause of action under paragraph (1) re-
22 lating to a denial of a claim for benefits where
23 a designated decisionmaker has not been ap-
24 pointed in accordance with this paragraph, the
25 plan sponsor or named fiduciary responsible for

1 determinations under section 503 shall be
2 deemed to be the designated decisionmaker.

3 “(3) REQUIREMENT OF EXHAUSTION OF INDE-
4 PENDENT MEDICAL REVIEW.—

5 “(A) IN GENERAL.—Paragraph (1) shall
6 apply only if—

7 “(i) a final determination denying a
8 claim for benefits under section 503A(b)
9 has been referred for independent medical
10 review under section 503B(d) and a writ-
11 ten determination by an independent med-
12 ical reviewer to reverse such final deter-
13 mination has been issued with respect to
14 such review, or

15 “(ii) the qualified external review enti-
16 ty has determined under section
17 503B(c)(3) that a referral to an inde-
18 pendent medical reviewer is not required.

19 “(B) INJUNCTIVE RELIEF FOR IRREP-
20 ARABLE HARM.—A participant or beneficiary
21 may seek relief under subsection 502(a)(1)(B)
22 prior to the exhaustion of administrative rem-
23 edies under section 503A(b) or 503B (as re-
24 quired under subparagraph (A)) if it is dem-
25 onstrated to the court, by a preponderance of

1 the evidence, that the exhaustion of such remedies
2 would cause irreparable harm to the
3 health of the participant or beneficiary. Any de-
4 terminations that already have been made
5 under section 503A or 503B in such case, or
6 that are made in such case while an action
7 under this subparagraph is pending, shall be
8 given due consideration by the court in any ac-
9 tion under this subsection in such case. Not-
10 withstanding the awarding of relief under sub-
11 section 502(a)(1)(B) pursuant to this subpara-
12 graph, no relief shall be available under—

13 “(i) paragraph (1), with respect to a
14 participant or beneficiary, unless the re-
15 quirements of subparagraph (A) are met;
16 or

17 “(ii) subsection (q) unless the require-
18 ments of such subsection are met.

19 “(4) LIMITATIONS ON RECOVERY OF DAM-
20 AGES.—

21 “(A) MAXIMUM AWARD OF NONECONOMIC
22 DAMAGES.—The aggregate amount of liability
23 for noneconomic loss in an action under para-
24 graph (1) may not exceed \$500,000.

1 “(B) SEVERAL LIABILITY.—In the case of
2 any action commenced pursuant to paragraph
3 (1), the designated decisionmaker shall be liable
4 only for the amount of damages attributable to
5 such designated decisionmaker in direct propor-
6 tion to such decisionmaker’s share of fault or
7 responsibility for the injury suffered by the par-
8 ticipant or beneficiary. In all such cases, the li-
9 ability of a designated decisionmaker for dam-
10 ages shall be several and not joint.

11 “(C) PROHIBITION OF AWARD OF PUNI-
12 TIVE DAMAGES.—Notwithstanding any other
13 provision of law, in the case of any action com-
14 menced pursuant to paragraph (1), the court
15 may not award any punitive, exemplary, or
16 similar damages against a defendant.

17 “(5) AFFIRMATIVE DEFENSES.—In the case of
18 any cause of action under paragraph (1), it shall be
19 an affirmative defense that—

20 “(A) the designated decisionmaker of a
21 group health plan, or health insurance issuer
22 that offers health insurance coverage in connec-
23 tion with a group health plan, involved did not
24 receive from the participant or beneficiary (or
25 authorized representative) or the treating health

1 care professional (if any), the information re-
2 quested by the plan or issuer regarding the
3 medical condition of the participant or bene-
4 ficiary that was necessary to make a determina-
5 tion on a claim for benefits under section
6 503A(a) or a final determination on a claim for
7 benefits under section 503A(b);

8 “(B) the participant or beneficiary (or au-
9 thorized representative) or treating health care
10 professional—

11 “(i) was in possession of facts that
12 were sufficient to enable the participant or
13 beneficiary (or authorized representative)
14 to know that an expedited review under
15 section 503A or 503B would have pre-
16 vented the harm that is the subject of the
17 action; and

18 “(ii) failed to notify the plan or issuer
19 of the need for such an expedited review;
20 or

21 “(C) the qualified external review entity or
22 an independent medical reviewer failed to meet
23 the timelines applicable under section 503B, or
24 a period of time elapsing after coverage has
25 been authorized.

1 Nothing in this paragraph shall be construed to limit
2 the application of any other affirmative defense that
3 may be applicable to the cause of action involved.

4 “(6) WAIVER OF INTERNAL REVIEW.—In the
5 case of any cause of action under paragraph (1), the
6 waiver or nonwaiver of internal review under section
7 503A(b)(1)(D) by the group health plan, or health
8 insurance issuer that offers health insurance cov-
9 erage in connection with a group health plan, shall
10 not be used in determining liability.

11 “(7) LIMITATIONS ON ACTIONS.—Paragraph
12 (1) shall not apply in connection with any action
13 that is commenced more than 5 years after the date
14 on which the failure described in such paragraph oc-
15 curred or, if earlier, not later than 2 years after the
16 first date the participant or beneficiary became
17 aware of the substantial harm referred to in such
18 paragraph.

19 “(8) EXCLUSION OF DIRECTED RECORD-
20 KEEPERS.—

21 “(A) IN GENERAL.—Paragraph (1) shall
22 not apply with respect to a directed record
23 keeper in connection with a group health plan.

24 “(B) DIRECTED RECORDKEEPER.—For
25 purposes of this paragraph, the term ‘directed

1 record keeper’ means, in connection with a
2 group health plan, a person engaged in directed
3 record keeping activities pursuant to the in-
4 structions of the plan, the employer, or another
5 plan sponsor, including the distribution of en-
6 rollment information and distribution of diselo-
7 sure materials under this Act or the Public
8 Health Service Act and whose duties do not in-
9 clude making determinations on claims for ben-
10 efits.

11 “(9) PROTECTION OF THE REGULATION OF
12 QUALITY OF MEDICAL CARE UNDER STATE LAW.—
13 Nothing in this subsection shall be construed to pre-
14 clude any action under State law against a person
15 or entity for liability or vicarious liability with re-
16 spect to the delivery of medical care. A claim that
17 is based on or otherwise relates to a group health
18 plan’s administration or determination of a claim for
19 benefits (as such term is defined in section
20 503B(i)(2) and notwithstanding the definition con-
21 tained in paragraph (14)(B)) shall not be deemed
22 to be the delivery of medical care under any State
23 law for purposes of this section. Any such claim
24 shall be maintained exclusively under section 502.
25 Nothing in this paragraph shall be construed as af-

1 fecting any action under State law that is permitted
2 under section 514(c).

3 “(10) COORDINATION WITH FIDUCIARY RE-
4 QUIREMENTS.—A fiduciary shall not be treated as
5 failing to meet any requirement of part 4 solely by
6 reason of any action taken by a fiduciary which con-
7 sists of full compliance with the reversal under sec-
8 tion 503B (relating to independent external appeals
9 procedures for group health plans) of a denial of
10 claim for benefits (within the meaning of section
11 503B(i)(2)).

12 “(11) CONSTRUCTION.—Nothing in this sub-
13 section shall be construed as authorizing a cause of
14 action under paragraph (1) for the failure of a
15 group health plan or health insurance issuer to pro-
16 vide an item or service that is specifically excluded
17 under the plan or coverage.

18 “(12) LIMITATION ON CLASS ACTION LITIGA-
19 TION.—A claim or cause of action under this sub-
20 section may not be maintained as a class action, as
21 a derivative action, or as an action on behalf of any
22 group of 2 or more claimants.

23 “(13) PREVENTION OF DUPLICATION OF AC-
24 TION WITH ACTION UNDER STATE LAW.—No action
25 may be brought under this subsection based upon

1 facts and circumstances if a cause of action under
2 State law (that is permitted under section 514 only
3 because of the application of subsection (c) of such
4 section) is brought based upon the same facts and
5 circumstances.

6 “(14) DEFINITIONS AND RELATED RULES.—

7 For purposes of this subsection:

8 “(A) AUTHORIZED REPRESENTATIVE.—

9 The term ‘authorized representative’ has the
10 meaning given such term in section 503B(i).

11 “(B) CLAIM FOR BENEFITS.—Except as

12 provided for in paragraph (8), the term ‘claim
13 for benefits’ shall have the meaning given such
14 term in section 503B(i), except that such term
15 shall only include claims for prior authorization
16 determinations (as such term is defined in sec-
17 tion 503B(i)).

18 “(C) GROUP HEALTH PLAN.—The term

19 ‘group health plan’ shall have the meaning
20 given such term in section 733(a).

21 “(D) HEALTH INSURANCE COVERAGE.—

22 The term ‘health insurance coverage’ has the
23 meaning given such term in section 733(b)(1).

1 “(E) HEALTH INSURANCE ISSUER.—The
2 term ‘health insurance issuer’ has the meaning
3 given such term in section 733(b)(2).

4 “(F) ORDINARY CARE.—The term ‘ordi-
5 nary care’ means the care, skill, prudence, and
6 diligence under the circumstances then pre-
7 vailing that a prudent individual acting in a like
8 capacity and familiar with such matters would
9 use in making a determination on a claim for
10 benefits of a similar character.

11 “(G) SUBSTANTIAL HARM.—The term
12 ‘substantial harm’ means the loss of life, loss or
13 significant impairment of limb or bodily func-
14 tion, significant mental illness or disease, sig-
15 nificant disfigurement, or severe and chronic
16 physical pain.

17 “(H) TREATMENT OF EXCEPTED BENE-
18 FITS.—The provisions of this subsection shall
19 not apply to excepted benefits (as defined in
20 section 733(c)), other than benefits described in
21 section 733(c)(2)(A), in the same manner as
22 the provisions of part 7 do not apply to such
23 benefits under subsections (b) and (c) of section
24 732.”.

1 (b) CONFORMING AMENDMENT.—Section
2 502(a)(1)(A) of the Employee Retirement Income Security
3 Act of 1974 (29 U.S.C. 1132(a)(1)(A)) is amended by in-
4 serting “or (n)” after “subsection (c)”.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to acts and omissions occurring
7 on or after the effective date contained in section 501 of
8 this Act.

9 **SEC. 142. TREATMENT OF STATE CAUSES OF ACTION WITH**
10 **RESPECT TO CERTAIN CLAIMS DENIALS BY**
11 **GROUP HEALTH PLANS.**

12 Section 514 of the Employee Retirement Income Se-
13 curity Act of 1974 (29 U.S.C. 1144) is amended—

14 (1) by redesignating subsections (c) and (d) as
15 subsections (d) and (e), respectively; and

16 (2) by inserting after subsection (b) the fol-
17 lowing new subsection:

18 “(c) TREATMENT OF STATE CAUSES OF ACTION
19 WITH RESPECT TO CERTAIN CLAIMS DENIALS BY GROUP
20 HEALTH PLANS.—

21 “(1) IN GENERAL.—Notwithstanding the pre-
22 ceding provisions of this section, a cause of action by
23 a participant or beneficiary under a group health
24 plan against the applicable designated decisionmaker
25 (within the meaning of section 502(o)) under State

1 law is not superseded by the provisions of this title
2 if—

3 “(A) the action is one for damages from
4 personal injury or for wrongful death proximi-
5 mately caused by a denial of a claim for bene-
6 fits, and

7 “(B) the conditions described in paragraph
8 (2) are met with respect to such denial.

9 “(2) FAILURE TO AUTHORIZE COVERAGE OR-
10 DERED BY INDEPENDENT MEDICAL REVIEWER.—
11 The conditions in this paragraph with respect to a
12 denial of a claim for benefits are met if—

13 “(A) the denial is reversed by a written de-
14 termination by an independent medical reviewer
15 under section 503B(d)(3)(F); and

16 “(B) there has been a failure to authorize
17 coverage in compliance with such written deter-
18 mination.

19 “(3) PREVENTION OF DUPLICATION OF ACTION
20 WITH ACTION UNDER FEDERAL LAW.—Paragraph
21 (1) shall not apply, in relation to a cause of action
22 under State law based upon facts and circumstances,
23 if a cause of action is brought under section 502(n)
24 based upon the same facts and circumstances.

1 “(4) DEFINITIONS AND RELATED RULES.—For
2 purposes of this subsection—

3 “(A) CLAIM FOR BENEFITS.—The term
4 ‘claim for benefits’ has the meaning provided
5 such term under section 503B(i)(2).

6 “(B) GROUP HEALTH PLAN.—The term
7 ‘group health plan’ has the meaning provided
8 such term under section 733(a)(1), except that
9 such term includes a plan, fund, or program
10 treated as a group health plan under section
11 732(d).

12 “(C) TREATMENT OF EXCEPTED BENE-
13 FITS.—The provisions of this subsection shall
14 not apply to excepted benefits (as defined in
15 section 733(c)), other than benefits described in
16 section 733(c)(2)(A), in the same manner as
17 the provisions of part 7 do not apply to such
18 benefits under subsections (b) and (c) of section
19 732.”.

20 **SEC. 143. LIMITATION ON CERTAIN CLASS ACTION LITIGA-**
21 **TION.**

22 (a) ERISA.—

23 (1) IN GENERAL.—Section 502 of the Employee
24 Retirement Income Security Act of 1974 (29 U.S.C.

1 1132), as amended by section 141, is further
2 amended by adding at the end the following:

3 “(o) LIMITATION ON CLASS ACTION LITIGATION.—
4 Any claim or cause of action that is maintained under this
5 section (other than under subsection (n)) or under section
6 1962 or 1964(c) of title 18, United States Code, in con-
7 nection with a group health plan, or health insurance cov-
8 erage issued in connection with a group health plan, as
9 a class action, derivative action, or as an action on behalf
10 of any group of 2 or more claimants, may be maintained
11 only if the class, the derivative claimant, or the group of
12 claimants is limited to the participants or beneficiaries of
13 a group health plan established by only 1 plan sponsor.
14 No action maintained by such class, such derivative claim-
15 ant, or such group of claimants may be joined in the same
16 proceeding with any action maintained by another class,
17 derivative claimant, or group of claimants or consolidated
18 for any purpose with any other proceeding. In this para-
19 graph, the terms ‘group health plan’ and ‘health insurance
20 coverage’ have the meanings given such terms in section
21 733.”.

22 (2) EFFECTIVE DATE.—The amendment made
23 by paragraph (1) shall apply with respect to actions
24 commenced on or after June 26, 2001. Notwith-
25 standing the preceding sentence, with respect to

1 class actions, the amendment made by paragraph
2 (1) shall apply with respect to civil actions which are
3 pending on such date in which a class action has not
4 been certified as of such date.

5 (b) RICO.—

6 (1) IN GENERAL.—Section 1964(c) of title 18,
7 United States Code, is amended—

8 (A) by inserting “(1)” after the subsection
9 designation; and

10 (B) by adding at the end the following:

11 “(2) No action may be brought under this subsection,
12 or alleging any violation of section 1962, where the action
13 seeks relief concerning the manner in which any person
14 has marketed, provided information concerning, estab-
15 lished, administered, or otherwise operated a group health
16 plan, or health insurance coverage in connection with a
17 group health plan. Any such action shall only be brought
18 under the Employee Retirement Income Security Act of
19 1974. In this paragraph, the terms ‘group health plan’
20 and ‘health insurance issuer’ shall have the meanings
21 given such terms in section 733 of the Employee Retire-
22 ment Income Security Act of 1974.”.

23 (2) EFFECTIVE DATE.—The amendments made
24 by paragraph (1) shall apply with respect to actions
25 commenced on or after June 26, 2001.

1 **Subtitle E—State Flexibility**

2 **SEC. 151. STATE FLEXIBILITY IN APPLYING REQUIRE-** 3 **MENTS TO HEALTH INSURANCE ISSUERS AND** 4 **NON-FEDERAL GOVERNMENTAL GROUP** 5 **HEALTH PLANS.**

6 (a) NONAPPLICATION OF CERTAIN FEDERAL RE-
7 REQUIREMENTS IN CASE OF QUALIFIED STATE REGULA-
8 TION.—

9 (1) IN GENERAL.—

10 (A) QUALIFIED STATE PATIENT PROTEC-
11 TIONS.—A patient protection requirement shall
12 not apply with respect to health insurance cov-
13 erage (and to a group health plan insofar as it
14 provides benefits in the form of health insur-
15 ance coverage) if there is a State law (as de-
16 fined in subsection (c)) that regulates such cov-
17 erage and that is substantially equivalent (as
18 provided under paragraph (2) or (4)) to such
19 requirement.

20 (B) INTERNAL AND EXTERNAL AP-
21 PEALS.—The requirements of section 503A or
22 503B of the Employee Retirement Income Se-
23 curity Act of 1974 shall not apply with respect
24 to individual health insurance coverage or to a
25 non-Federal governmental group health plan if

1 there is a State law that regulates such cov-
2 erage or plan and that is substantially equiva-
3 lent (as provided under paragraph (2) or (4)) to
4 the section.

5 (C) PATIENT PROTECTION REQUIREMENT
6 DEFINED.—For purposes of this section, the
7 term “patient protection requirement” means
8 any one or more requirements under the fol-
9 lowing:

10 (i) Section 101 (relating to access to
11 emergency care).

12 (ii) Section 102 (relating to consumer
13 choice option) with respect to non-Federal
14 governmental plans only.

15 (iii) Section 103 (relating to patient
16 access to obstetric and gynecological care).

17 (iv) Section 104 (relating to access to
18 pediatric care).

19 (v) Section 105 (relating to timely ac-
20 cess to specialists).

21 (vi) Section 106 (relating to con-
22 tinuity of care), but only insofar as a re-
23 placement issuer assumes the obligation
24 for continuity of care.

1 (vii) Section 108 (relating to access to
2 needed prescription drugs).

3 (viii) Section 109 (relating to coverage
4 for individuals participating in approved
5 clinical trials).

6 (ix) A prohibition under—

7 (I) section 107 (relating to prohi-
8 bition of interference with certain
9 medical communications); and

10 (II) section 110 (relating to pro-
11 hibition of discrimination against pro-
12 viders based on licensure).

13 (x) An informational requirement
14 under section 121.

15 (2) STATE CERTIFICATION OF SUBSTANTIAL
16 EQUIVALENCE.—

17 (A) IN GENERAL.—For purposes of para-
18 graph (1), a State law that imposes require-
19 ments that relate to a section in Federal law re-
20ferred to in such paragraph is deemed to be
21 substantially equivalent to that section if the
22 chief executive officer of the State, not later
23 than the deadline specified in subparagraph
24 (D), submits to the Secretary of Health and
25 Human Services a certification described in

1 subparagraph (B). Such certification shall be
2 effective under paragraph (1) until otherwise
3 provided under paragraph (3)(C) or (3)(D).

4 (B) DESCRIPTION OF CERTIFICATION.—A
5 certification described in this subparagraph is,
6 with respect to a State law in relation to a sec-
7 tion of Federal law referred to in paragraph
8 (1), a certification that there is a reasonable
9 basis to find that the State law imposes re-
10 quirements that, taken as a whole and consid-
11 ering the need for flexibility in the application
12 of such section in relation to applicable State
13 law, provide protections that are substantially
14 equivalent to or greater than the protections to
15 participants and beneficiaries provided under
16 such section.

17 (C) PROCEDURES.—The Secretary of
18 Health and Human Services shall by regulation
19 establish procedures to carry out this sub-
20 section.

21 (D) DEADLINE.—The deadline specified in
22 this subparagraph is 90 days after the date reg-
23 ulations described in subparagraph (C) are first
24 promulgated.

1 (3) OPPORTUNITY FOR SECRETARIAL REVIEW
2 AND DETERMINATION.—

3 (A) NOTICE OF RECEIPT OF CERTIFI-
4 CATION.—The Secretary of Health and Human
5 Services shall provide for public notice upon re-
6 ceipt of a certification submitted under para-
7 graph (2). Such Secretary may review such a
8 certification to determine preliminarily whether
9 there is a reasonable basis for the certification,

10 (B) NOTICE OF PRELIMINARY DIS-
11 APPROVAL.—A certification under paragraph
12 (2) shall be effective unless such Secretary de-
13 termines, within 90 days of the date of its sub-
14 mittal, that there is not a reasonable basis for
15 the certification. Such Secretary shall provide
16 notice to the State and the public of such deter-
17 mination. Such notice shall include an expla-
18 nation of the basis for the determination and
19 shall identify specific deficiencies in the State
20 law. The provision of such notice shall not sus-
21 pend the effectiveness of the State certification.

22 (C) FINAL DETERMINATION.—If such Sec-
23 retary has made a determination described in
24 subparagraph (B), such Secretary shall make a
25 final determination regarding whether there is a

1 reasonable basis for the certification. Such Sec-
2 retary shall provide notice of such final deter-
3 mination in the same manner as for determina-
4 tions under subparagraph (B). If such Sec-
5 retary decides that there is not a reasonable
6 basis for the certification, such Secretary shall
7 specify a time period (of not less than one year)
8 by the end of which the certification will no
9 longer be effective. Such determination shall
10 take effect (and the effectiveness of the certifi-
11 cation suspended) at the end of the period for
12 filing judicial review of such determination
13 under subparagraph (D) unless the State files
14 for judicial review. If the State files for judicial
15 review the certification shall remain in effect
16 during the period of judicial review and until
17 such time as ordered by the court under sub-
18 paragraph (D).

19 (D) JUDICIAL REVIEW.—A final deter-
20 mination of the Secretary under subparagraph
21 (C) is subject to judicial review under chapter
22 5 of title 5, United States Code, in the Circuit
23 Court of Appeals for the State certification of
24 which is challenged. To find for such Secretary,
25 the court must find that there is not a reason-

1 able basis for the certification. If the court up-
2 holds the final determination of such Secretary,
3 the certification shall remain in effect until
4 such date as the court may specify in order to
5 provide for an orderly transition.

6 (4) STATE CERTIFICATIONS AFTER FEDERAL
7 PROVISIONS HAVE TAKEN EFFECT.—After a section
8 of Federal law referred to in paragraph (1) has
9 taken effect, a State may nonetheless submit a cer-
10 tification described in paragraph (2)(B). Such a cer-
11 tification shall only become effective if—

12 (A) there is no challenge of the certifi-
13 cation by the Secretary of Health and Human
14 Services within 90 days after the date of its
15 submittal;

16 (B) such Secretary concurs in the certifi-
17 cation; or

18 (C) such Secretary challenges the certifi-
19 cation but such challenge is not upheld in court;
20 and not until 1 year after the expiration of such 90-
21 day period, the date of the Secretary's concurrence,
22 or the date a court does not uphold the Secretary's
23 challenge, as the case may be.

24 (b) RELATIONSHIP OF QUALIFIED STATE PATIENT
25 PROTECTIONS TO PLANS UNDER ERISA.—

1 (1) IN GENERAL.—Nothing in this section shall
2 be construed to affect or modify the provisions of
3 section 514 of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1144) with respect to
5 group health plans. In any case in which health in-
6 surance coverage is provided by a health insurance
7 issuer in connection with a group health plan to
8 which title I of such Act applies and there is a State
9 law described in subsection (a)(1)(A) that regulates
10 such coverage and that is substantially equivalent
11 (as provided under paragraph (2) or (4) of sub-
12 section (a)) to requirements of a section of Federal
13 law referred to in subsection (a)(1)(A), to the extent
14 that such State law, as applicable to such plan, is
15 superseded by such title, the provisions of such State
16 law shall be deemed (including for purposes of ap-
17 plying administration and enforcement of part 5 of
18 subtitle B of title I of such Act) to be substituted
19 for (and incorporated as) the corresponding section
20 of Federal law referred to in subsection (a)(1)(A) in-
21 sofar as the plan provides benefits by means of such
22 coverage.

23 (2) PREVENTING APPLICATION OF STATE LAW
24 IN CASES WHERE FEDERAL LAW IS APPLIED.—In
25 any case in which, after applying the provisions of

1 this subsection with respect to a section of Federal
2 law described referred to in subsection (a)(1)(A), the
3 requirements of such section remain applicable with
4 respect to health insurance coverage (and to a group
5 health plan insofar as it provides benefits in the
6 form of health insurance coverage) in a State, any
7 State law that imposes requirements within the
8 scope of the subject matter and protections provided
9 by such section, taken as a whole, is preempted and
10 does not apply.

11 (c) DEFINITIONS.—For purposes of this section, the
12 terms “State” and “State law” shall have the meanings
13 given such terms in section 2723(d) of the Public Health
14 Service Act (42 U.S.C. 300gg–23(d)).

15 **Subtitle F—Miscellaneous** 16 **Provisions**

17 **SEC. 161. DEFINITIONS.**

18 (a) INCORPORATION OF GENERAL DEFINITIONS.—
19 Except as otherwise provided, the provisions of section
20 2791 of the Public Health Service Act shall apply for pur-
21 poses of this title in the same manner as they apply for
22 purposes of title XXVII of such Act.

23 (b) SECRETARY.—Except as otherwise provided, the
24 term “Secretary” means the Secretary of Health and

1 Human Services, in consultation with the Secretary of
2 Labor.

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

5 (1) ENROLLEE.—The term “enrollee” means,
6 with respect to health insurance coverage offered by
7 a health insurance issuer, an individual enrolled with
8 the issuer to receive such coverage.

9 (2) HEALTH CARE PROFESSIONAL.—The term
10 “health care professional” means an individual who
11 is licensed, accredited, or certified under State law
12 to provide specified health care services and who is
13 operating within the scope of such licensure, accredi-
14 tation, or certification.

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

22 (4) NETWORK.—The term “network” means,
23 with respect to a group health plan or health insur-
24 ance issuer offering health insurance coverage, the
25 participating health care professionals and providers

1 through whom the plan or issuer provides health
2 care items and services to participants, beneficiaries,
3 or enrollees.

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

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

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

24 (8) TERMS AND CONDITIONS.—The term
25 “terms and conditions” includes, with respect to a

1 group health plan or health insurance coverage, re-
2 quirements imposed under this title (and sections
3 503A and 503B of the Employee Retirement Income
4 Security Act of 1974) with respect to the plan or
5 coverage.

6 **SEC. 162. EXCLUSIONS.**

7 (a) **NO BENEFIT REQUIREMENTS.**—Nothing in this
8 title (or the amendments made by this title) shall be con-
9 strued to require a group health plan or a health insurance
10 issuer offering health insurance coverage to provide spe-
11 cific benefits under the terms of such plan or coverage,
12 other than those provided under the terms of such plan
13 or coverage.

14 (b) **EXCLUSION FOR FEE-FOR-SERVICE COV-**
15 **ERAGE.**—

16 (1) **IN GENERAL.**—The provisions of subtitle A
17 shall not apply to a group health plan or health in-
18 surance coverage if the only coverage offered under
19 such plan or coverage is fee-for-service coverage (as
20 defined in paragraph (2)).

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

1 (A) reimburses hospitals, health profes-
2 sionals, and other providers on a fee-for-service
3 basis without placing the provider at financial
4 risk;

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

9 (C) allows access to any provider that is
10 lawfully authorized to provide the covered serv-
11 ices and agree to accept the terms of payment
12 established under the plan or by the issuer; and

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

16 Notwithstanding subparagraph (D), coverage that
17 would satisfy the coverage requirements established
18 for an indemnity benefit plan or a service benefit
19 plan under the Federal employees health benefits
20 program under chapter 89 of title 5, United States
21 Code, and any related regulations and rules promul-
22 gated by the Office of Personnel Management, shall
23 be considered to meet the definition of fee-for-service
24 coverage under this paragraph.

1 (c) TREATMENT OF EXCEPTED BENEFITS.—The re-
2 quirements of this title shall not apply to excepted benefits
3 (as defined in section 733(c) of the Employee Retirement
4 Income Security Act of 1974, 29 U.S.C. 1191b(c)), other
5 than benefits described in section 733(c)(2)(A) of such
6 Act, in the same manner as the provisions of part 7 of
7 subtitle B of title I of such Act do not apply to such bene-
8 fits under subsections (b) and (c) of section 732 of such
9 Act (29 U.S.C. 1191a).

10 (d) RULE WITH RESPECT TO CERTAIN PLANS.—

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

21 (2) EXISTING STATE LAWS.—A State law relat-
22 ing to payment for health preempted under para-
23 graph (1), shall not apply to high deductible health
24 plans after the expiration of the 5-year period de-

1 scribed in such paragraph unless the State reenacts
2 such law after such period.

3 **TITLE II—AMENDMENTS TO THE**
4 **PUBLIC HEALTH SERVICE ACT**

5 **SEC. 201. APPLICATION TO CERTAIN HEALTH INSURANCE**
6 **COVERAGE.**

7 (a) IN GENERAL.—Subpart 2 of part A of title
8 XXVII of the Public Health Service Act (42 U.S.C.
9 300gg-4 et seq.) is amended by adding at the end the
10 following:

11 **“SEC. 2707. PATIENT PROTECTION STANDARDS AND AC-**
12 **COUNTABILITY.**

13 “(a) IN GENERAL.—Each health insurance issuer
14 shall comply with the patient protection requirements
15 under title I of the Patients’ Bill of Rights Act of 2001
16 with respect to non-Federal governmental group health in-
17 surance coverage offered by such issuers, and such re-
18 quirements shall be deemed to be incorporated into this
19 section.

20 “(b) ACCOUNTABILITY.—The provisions of sections
21 503 through 503B of the Employee Retirement Income
22 Security Act of 1974 (as in effect as of the day after the
23 date of enactment of the Patients’ Bill of Rights Act of
24 2001) shall apply to non-Federal governmental group
25 health insurance coverage offered by health insurance

1 issuers with respect to an enrollee in the same manner
2 as they apply to health insurance coverage offered by a
3 health insurance issuer for a participant or beneficiary in
4 connection with a group health plan and the requirements
5 referred to in such sections shall be deemed to be incor-
6 porated into this section. For purposes of this subsection,
7 references in such sections 503 through 503B to the Sec-
8 retary shall be deemed to be references to the Secretary
9 of Health and Human Services.

10 “(c) CONSTRUCTION.—Nothing in this section shall
11 be construed to affect section 2721(b)(2).”.

12 (b) CONFORMING AMENDMENT.—Section
13 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))
14 is amended by inserting “(other than section 2707)” after
15 “requirements of such subparts”.

16 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
17 **ANCE COVERAGE.**

18 Part B of title XXVII of the Public Health Service
19 Act (42 U.S.C. 300gg–41 et seq.) is amended—

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

22 (2) by inserting after section 2752 the fol-
23 lowing:

1 **“SEC. 2753. PATIENT PROTECTION STANDARDS AND AC-**
2 **COUNTABILITY.**

3 “(a) IN GENERAL.—Each health insurance issuer
4 shall comply with the patient protection requirements
5 under subtitles A and B of title I of the Patients’ Bill
6 of Rights Act of 2001 with respect to individual health
7 insurance coverage it offers, and such requirements shall
8 be deemed to be incorporated into this section.

9 “(b) ACCOUNTABILITY.—The provisions of sections
10 503 through 503B of the Employee Retirement Income
11 Security Act of 1974 (as in effect as of the day after the
12 date of enactment of the Patients’ Bill of Rights Act of
13 2001) shall apply to health insurance coverage offered by
14 a health insurance issuer in the individual market with
15 respect to an enrollee in the same manner as they apply
16 to health insurance coverage offered by a health insurance
17 issuer for a participant or beneficiary in connection with
18 a group health plan and the requirements referred to in
19 such sections shall be deemed to be incorporated into this
20 section. For purposes of this subsection, references in such
21 sections 503 through 503B to the Secretary shall be
22 deemed to be references to the Secretary of Health and
23 Human Services.”.

1 **TITLE III—AMENDMENTS TO**
2 **THE EMPLOYEE RETIREMENT**
3 **INCOME SECURITY ACT OF**
4 **1974**

5 **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**
6 **ARDS TO GROUP HEALTH PLANS AND GROUP**
7 **HEALTH INSURANCE COVERAGE UNDER THE**
8 **EMPLOYEE RETIREMENT INCOME SECURITY**
9 **ACT OF 1974.**

10 (a) IN GENERAL.—Subpart B of part 7 of subtitle
11 B of title I of the Employee Retirement Income Security
12 Act of 1974 (29 U.S.C. 1185 et seq.) is further amended
13 by adding at the end the following new section:

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

15 “(a) IN GENERAL.—Subject to subsection (b), a
16 group health plan (and a health insurance issuer offering
17 health insurance coverage in connection with a group
18 health plan) shall comply with the requirements of title
19 I of the Patients’ Bill of Rights Act of 2001 (as in effect
20 as of the date of the enactment of such Act), and such
21 requirements shall be deemed to be incorporated into this
22 subsection.

23 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-
24 MENTS.—

1 “(1) SATISFACTION OF CERTAIN REQUIRE-
2 MENTS THROUGH INSURANCE.—For purposes of
3 subsection (a), insofar as a group health plan pro-
4 vides benefits in the form of health insurance cov-
5 erage through a health insurance issuer, the plan
6 shall be treated as meeting the following require-
7 ments of title I of the Patients’ Bill of Rights Act
8 of 2001 with respect to such benefits and not be
9 considered as failing to meet such requirements be-
10 cause of a failure of the issuer to meet such require-
11 ments so long as the plan sponsor or its representa-
12 tives did not cause such failure by the issuer:

13 “(A) Section 101 (relating to access to
14 emergency care).

15 “(B) Section 102 (relating to consumer
16 choice option).

17 “(C) Section 103 (relating to patient ac-
18 cess to obstetric and gynecological care).

19 “(D) Section 104 (relating to access to pe-
20 diatric care).

21 “(E) Section 105 (relating to timely access
22 to specialists).

23 “(F) Section 106 (relating to continuity of
24 care), but only insofar as a replacement issuer
25 assumes the obligation for continuity of care.

1 “(G) Section 108 (relating to access to
2 needed prescription drugs).

3 “(H) Section 109 (relating to coverage for
4 individuals participating in approved clinical
5 trials).

6 “(I) Section 121 (relating to the provision
7 of information).

8 “(2) APPLICATION TO PROHIBITIONS.—Pursu-
9 ant to rules of the Secretary, if a health insurance
10 issuer offering health insurance coverage in connec-
11 tion with a group health plan takes an action in vio-
12 lation of any of the following sections of the Pa-
13 tients’ Bill of Rights Act of 2001, the group health
14 plan shall not be liable for such violation unless the
15 plan caused such violation:

16 “(A) Section 107 (relating to prohibition of
17 interference with certain medical communica-
18 tions).

19 “(B) Section 110 (relating to prohibition
20 of discrimination against providers based on li-
21 censure).

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

1 “(4) TREATMENT OF CONSISTENT STATE
2 LAWS.—For purposes of applying this subsection, a
3 health insurance issuer offering coverage in connec-
4 tion with a group health plan (and such group
5 health plan) shall be deemed to be in compliance
6 with one or more of the patient protection require-
7 ments of the Patients’ Bill of Rights Act of 2001 (as
8 defined in section 151(a)(1)(C) of such Act) that are
9 otherwise applicable to such issuer (or plan) under
10 this section where the issuer (or plan) is in compli-
11 ance with a State law, with respect to the patient
12 protection requirements involved, that has been cer-
13 tified in accordance with section 151 of such Act.

14 “(c) CONFORMING REGULATIONS.—The Secretary
15 shall issue regulations to coordinate the requirements on
16 group health plans and health insurance issuers under this
17 section with the requirements imposed under the other
18 provisions of this title.”.

19 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
20 REQUIREMENT.—Section 503 of the Employee Retirement
21 Income Security Act of 1974 (29 U.S.C. 1133) is
22 amended—

- 23 (1) by inserting “(a)” after “SEC. 503.”; and
24 (2) by adding at the end the following:

1 “(b) In the case of a group health plan (as defined
2 in section 733) compliance with the requirements of sub-
3 title A of title I of the Patients’ Bill of Rights Act of 2001,
4 and compliance with regulations promulgated by the Sec-
5 retary, in the case of a claims denial shall be deemed com-
6 pliance with subsection (a) with respect to such claims de-
7 nial.”.

8 (c) ENFORCEMENT.—Section 502(b)(3) of the Em-
9 ployee Retirement Income Security Act of 1974 (29
10 U.S.C. 1132(b)(3)) is amended—

11 (1) by striking “The Secretary” and inserting
12 “(A) The Secretary”; and

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

14 “(B) A participant, beneficiary, plan fiduciary, or the
15 Secretary may not bring an action to enforce the require-
16 ments of section 714 against a health insurance issuer of-
17 fering coverage in connection with a group health plan (or
18 such group health plan) where the patient protection re-
19 quirements of the Patients’ Bill of Rights Act of 2001 (as
20 defined in section 151(a)(1)(C) of such Act) otherwise ap-
21 plicable to such issuer (or plan) under section 714 do not
22 apply because the issuer (or plan) is in compliance with
23 a State law, with respect to the patient protection require-
24 ments involved, that has been certified or a determination
25 made in accordance with section 151 of such Act.”.

1 (d) CONFORMING AMENDMENTS.—

2 (1) Section 732(a) of the Employee Retirement
3 Income Security Act of 1974 (29 U.S.C. 1185(a)) is
4 amended by striking “section 711” and inserting
5 “sections 711 and 714”.

6 (2) The table of contents in section 1 of the
7 Employee Retirement Income Security Act of 1974
8 is amended by inserting after the item relating to
9 section 713 the following new item:

“Sec. 714. Patient protection standards.”.

10 (3) Section 502(b)(3) of the Employee Retire-
11 ment Income Security Act of 1974 (29 U.S.C.
12 1132(b)(3)) is amended by inserting “(other than
13 section 135(b))” after “part 7”.

14 (4) Section 731(a)(1) of such Act (29 U.S.C.
15 1191(a)(1)) is amended by inserting “and section
16 151 of the Patients’ Bill of Rights Act of 2001”
17 after “Subject to paragraph (2)”.

18 **TITLE IV—AMENDMENTS TO THE**
19 **INTERNAL REVENUE CODE**
20 **OF 1986**

21 **SEC. 401. APPLICATION TO GROUP HEALTH PLANS UNDER**
22 **THE INTERNAL 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 subtitles A and B title I of the Patients’ Bill
11 of Rights Act of 2001 (and subtitle F of such title insofar
12 as it applies to such subtitles A and B) and of sections
13 503A and 503B of the Employee Retirement Income Se-
14 curity Act of 1974, as such requirements are in effect as
15 of the date of the enactment of such Act, and such require-
16 ments shall be deemed to be incorporated into this sec-
17 tion.”.

18 **TITLE V—EFFECTIVE DATE;**
19 **SEVERABILITY**

20 **SEC. 501. EFFECTIVE DATE AND RELATED RULES.**

21 (a) IN GENERAL.—Except as otherwise provided in
22 this Act, the provisions of this Act, including the amend-
23 ments made by title I, shall apply—

1 (1) to group health plans, and health insurance
2 coverage offered in connection with such plans, on
3 the later of—

4 (A) plan years beginning on or after Janu-
5 ary 1 of the first calendar year that begins
6 more than 1 year after the date of the enact-
7 ment of this Act; or

8 (B) plan years beginning on or after 18
9 months after the date on which the Secretary of
10 Health and Human Services and the Secretary
11 of Labor issue final regulations, subject to the
12 notice and comment period required under sub-
13 chapter 2 of chapter 5 of title 5, United States
14 Code, necessary to carry out such provisions
15 and the amendments made by this Act; and

16 (2) to individual health insurance coverage be-
17 ginning on or after the effective date described in
18 paragraph (1)(A).

19 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
20 enforcement action shall be taken, pursuant to the amend-
21 ments made by this Act, against a group health plan with
22 respect to a violation of a requirement imposed by such
23 amendments before the date of issuance of regulations
24 issued in connection with such requirement, if the plan
25 has sought to comply in good faith with such requirement.

1 (c) TREATMENT OF RELIGIOUS NONMEDICAL PRO-
2 VIDERS.—

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

5 (A) restrict or limit the right of group
6 health plans, and of health insurance issuers of-
7 fering health insurance coverage, to include as
8 providers religious nonmedical providers;

9 (B) require such plans or issuers to—

10 (i) utilize medically based eligibility
11 standards or criteria in deciding provider
12 status of religious nonmedical providers;

13 (ii) use medical professionals or cri-
14 teria to decide patient access to religious
15 nonmedical providers;

16 (iii) utilize medical professionals or
17 criteria in making determinations in inter-
18 nal or external appeals regarding coverage
19 for care by religious nonmedical providers;
20 or

21 (iv) compel a participant or bene-
22 ficiary to undergo a medical examination
23 or test as a condition of receiving health
24 insurance coverage for treatment by a reli-
25 gious nonmedical provider; or

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

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

13 **SEC. 502. SEVERABILITY.**

14 (a) IN GENERAL.—Except as provided in subsections
15 (b) and (c), if any provision of this Act, an amendment
16 made by this Act, or the application of such provision or
17 amendment to any person or circumstance is held to be
18 unconstitutional, the remainder of this Act, the amend-
19 ments made by this Act, and the application of the provi-
20 sions of such to any person or circumstance shall not be
21 affected thereby.

22 (b) DEPENDENCE OF REMEDIES ON APPEALS.—If
23 any provision of section 131, or the amendments made by
24 such section, or the application of such section or amend-
25 ments to any person or circumstance is held to be uncon-

1 stitutional, sections 141 and 142 and the amendments
2 made by such sections, shall be deemed to be null and
3 void and shall be given no force or effect.

4 (c) REMEDIES.—If any provision of section 141 or
5 142, or the amendments made by such section, or the ap-
6 plication of such section or amendments to any person or
7 circumstance is held to be unconstitutional, the remainder
8 of such section, and the amendments made by such section
9 shall be deemed to be null and void and shall be given
10 no force or effect.

11 **TITLE VI—INCREASING ACCESS**
12 **TO AFFORDABLE HEALTH IN-**
13 **SURANCE**

14 **Subtitle A—Tax Incentives**

15 **SEC. 601. EXPANSION OF AVAILABILITY OF ARCHER MED-**
16 **ICAL SAVINGS ACCOUNTS.**

17 (a) REPEAL OF LIMITATIONS ON NUMBER OF MED-
18 ICAL SAVINGS ACCOUNTS.—

19 (1) IN GENERAL.—Subsections (i) and (j) of
20 section 220 of the Internal Revenue Code of 1986
21 are hereby repealed.

22 (2) CONFORMING AMENDMENTS.—

23 (A) Paragraph (1) of section 220(c) of
24 such Code is amended by striking subparagraph
25 (D).

1 (B) Section 138 of such Code is amended
2 by striking subsection (f).

3 (b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR
4 EMPLOYEES OF SMALL EMPLOYERS AND SELF-EM-
5 PLOYED INDIVIDUALS.—

6 (1) IN GENERAL.—Subparagraph (A) of section
7 220(c)(1) of such Code (relating to eligible indi-
8 vidual) is amended to read as follows:

9 “(A) IN GENERAL.—The term ‘eligible in-
10 dividual’ means, with respect to any month, any
11 individual if—

12 “(i) such individual is covered under a
13 high deductible health plan as of the 1st
14 day of such month, and

15 “(ii) such individual is not, while cov-
16 ered under a high deductible health plan,
17 covered under any health plan—

18 “(I) which is not a high deduct-
19 ible health plan, and

20 “(II) which provides coverage for
21 any benefit which is covered under the
22 high deductible health plan.”.

23 (2) CONFORMING AMENDMENTS.—

24 (A) Section 220(c)(1) of such Code is
25 amended by striking subparagraph (C).

1 (B) Section 220(c) of such Code is amend-
2 ed by striking paragraph (4) (defining small
3 employer) and by redesignating paragraph (5)
4 as paragraph (4).

5 (C) Section 220(b) of such Code is amend-
6 ed by striking paragraph (4) (relating to deduc-
7 tion limited by compensation) and by redesign-
8 ating paragraphs (5), (6), and (7) as para-
9 graphs (4), (5), and (6), respectively.

10 (c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED
11 FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

12 (1) IN GENERAL.—Paragraph (2) of section
13 220(b) of such Code is amended to read as follows:

14 “(2) MONTHLY LIMITATION.—The monthly lim-
15 itation for any month is the amount equal to $\frac{1}{12}$ of
16 the annual deductible (as of the first day of such
17 month) of the individual’s coverage under the high
18 deductible health plan.”.

19 (2) CONFORMING AMENDMENT.—Clause (ii) of
20 section 220(d)(1)(A) of such Code is amended by
21 striking “75 percent of”.

22 (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-
23 TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph
24 (4) of section 220(b) of such Code (as redesignated by
25 subsection (b)(2)(C)) is amended to read as follows:

1 “(4) COORDINATION WITH EXCLUSION FOR EM-
2 PLOYER CONTRIBUTIONS.—The limitation which
3 would (but for this paragraph) apply under this sub-
4 section to the taxpayer for any taxable year shall be
5 reduced (but not below zero) by the amount which
6 would (but for section 106(b)) be includible in the
7 taxpayer’s gross income for such taxable year.”.

8 (e) REDUCTION OF PERMITTED DEDUCTIBLES
9 UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

10 (1) IN GENERAL.—Subparagraph (A) of section
11 220(c)(2) of such Code (defining high deductible
12 health plan) is amended—

13 (A) by striking “\$1,500” in clause (i) and
14 inserting “\$1,000”; and

15 (B) by striking “\$3,000” in clause (ii) and
16 inserting “\$2,000”.

17 (2) CONFORMING AMENDMENT.—Subsection (g)
18 of section 220 of such Code is amended to read as
19 follows:

20 “(g) COST-OF-LIVING ADJUSTMENT.—

21 “(1) IN GENERAL.—In the case of any taxable
22 year beginning in a calendar year after 1998, each
23 dollar amount in subsection (c)(2) shall be increased
24 by an amount equal to—

25 “(A) such dollar amount, multiplied by

1 “(B) the cost-of-living adjustment deter-
2 mined under section 1(f)(3) for the calendar
3 year in which such taxable year begins by sub-
4 stituting ‘calendar year 1997’ for ‘calendar year
5 1992’ in subparagraph (B) thereof.

6 “(2) SPECIAL RULES.—In the case of the
7 \$1,000 amount in subsection (c)(2)(A)(i) and the
8 \$2,000 amount in subsection (c)(2)(A)(ii), para-
9 graph (1)(B) shall be applied by substituting ‘cal-
10 endar year 2000’ for ‘calendar year 1997’.

11 “(3) ROUNDING.—If any increase under para-
12 graph (1) or (2) is not a multiple of \$50, such in-
13 crease shall be rounded to the nearest multiple of
14 \$50.”.

15 (f) PROVIDING INCENTIVES FOR PREFERRED PRO-
16 VIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS AC-
17 COUNTS.—Clause (ii) of section 220(c)(2)(B) of such Code
18 is amended by striking “preventive care if” and all that
19 follows and inserting “preventive care.”

20 (g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED
21 UNDER CAFETERIA PLANS.—Subsection (f) of section
22 125 of such Code is amended by striking “106(b),”.

23 (h) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to taxable years beginning after
25 December 31, 2001.

1 **Subtitle B—Association Health**
 2 **Plans**

3 **SEC. 621. RULES GOVERNING ASSOCIATION HEALTH**
 4 **PLANS.**

5 (a) IN GENERAL.—Subtitle B of title I of the Em-
 6 ployee Retirement Income Security Act of 1974 is amend-
 7 ed by adding after part 7 the following new part:

8 “PART 8—RULES GOVERNING ASSOCIATION HEALTH
 9 PLANS

10 “**SEC. 801. ASSOCIATION HEALTH PLANS.**

11 “(a) IN GENERAL.—For purposes of this part, the
 12 term ‘association health plan’ means a group health plan
 13 whose sponsor is (or is deemed under this part to be) de-
 14 scribed in subsection (b).

15 “(b) SPONSORSHIP.—The sponsor of a group health
 16 plan is described in this subsection if such sponsor—

17 “(1) is organized and maintained in good faith,
 18 with a constitution and bylaws specifically stating its
 19 purpose and providing for periodic meetings on at
 20 least an annual basis, as a bona fide trade associa-
 21 tion, a bona fide industry association (including a
 22 rural electric cooperative association or a rural tele-
 23 phone cooperative association), a bona fide profes-
 24 sional association, or a bona fide chamber of com-
 25 merce (or similar bona fide business association, in-

1 including a corporation or similar organization that
2 operates on a cooperative basis (within the meaning
3 of section 1381 of the Internal Revenue Code of
4 1986)), for substantial purposes other than that of
5 obtaining or providing medical care;

6 “(2) is established as a permanent entity which
7 receives the active support of its members and col-
8 lects from its members on a periodic basis dues or
9 payments necessary to maintain eligibility for mem-
10 bership in the sponsor; and

11 “(3) does not condition membership, such dues
12 or payments, or coverage under the plan on the
13 basis of health status-related factors with respect to
14 the employees of its members (or affiliated mem-
15 bers), or the dependents of such employees, and does
16 not condition such dues or payments on the basis of
17 group health plan participation.

18 Any sponsor consisting of an association of entities which
19 meet the requirements of paragraphs (1), (2), and (3)
20 shall be deemed to be a sponsor described in this sub-
21 section.

22 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**
23 **PLANS.**

24 “(a) IN GENERAL.—The applicable authority shall
25 prescribe by regulation, through negotiated rulemaking, a

1 procedure under which, subject to subsection (b), the ap-
2 plicable authority shall certify association health plans
3 which apply for certification as meeting the requirements
4 of this part.

5 “(b) STANDARDS.—Under the procedure prescribed
6 pursuant to subsection (a), in the case of an association
7 health plan that provides at least one benefit option which
8 does not consist of health insurance coverage, the applica-
9 ble authority shall certify such plan as meeting the re-
10 quirements of this part only if the applicable authority is
11 satisfied that the applicable requirements of this part are
12 met (or, upon the date on which the plan is to commence
13 operations, will be met) with respect to the plan.

14 “(c) REQUIREMENTS APPLICABLE TO CERTIFIED
15 PLANS.—An association health plan with respect to which
16 certification under this part is in effect shall meet the ap-
17 plicable requirements of this part, effective on the date
18 of certification (or, if later, on the date on which the plan
19 is to commence operations).

20 “(d) REQUIREMENTS FOR CONTINUED CERTIFI-
21 CATION.—The applicable authority may provide by regula-
22 tion, through negotiated rulemaking, for continued certifi-
23 cation of association health plans under this part.

24 “(e) CLASS CERTIFICATION FOR FULLY INSURED
25 PLANS.—The applicable authority shall establish a class

1 certification procedure for association health plans under
2 which all benefits consist of health insurance coverage.
3 Under such procedure, the applicable authority shall pro-
4 vide for the granting of certification under this part to
5 the plans in each class of such association health plans
6 upon appropriate filing under such procedure in connec-
7 tion with plans in such class and payment of the pre-
8 scribed fee under section 807(a).

9 “(f) CERTIFICATION OF SELF-INSURED ASSOCIATION
10 HEALTH PLANS.—An association health plan which offers
11 one or more benefit options which do not consist of health
12 insurance coverage may be certified under this part only
13 if such plan consists of any of the following:

14 “(1) a plan which offered such coverage on the
15 date of the enactment of the Patients’ Bill of Rights
16 Act of 2001,

17 “(2) a plan under which the sponsor does not
18 restrict membership to one or more trades and busi-
19 nesses or industries and whose eligible participating
20 employers represent a broad cross-section of trades
21 and businesses or industries, or

22 “(3) a plan whose eligible participating employ-
23 ers represent one or more trades or businesses, or
24 one or more industries, which have been indicated as
25 having average or above-average health insurance

1 risk or health claims experience by reason of State
2 rate filings, denials of coverage, proposed premium
3 rate levels, and other means demonstrated by such
4 plan in accordance with regulations which the Sec-
5 retary shall prescribe through negotiated rule-
6 making, including (but not limited to) the following:
7 agriculture; equipment and automobile dealerships;
8 barbering and cosmetology; beverage wholesaling/dis-
9 tributing; certified public accounting practices; child
10 care; construction; dance, theatrical, and orchestra
11 productions; disinfecting and pest control; eating
12 and drinking establishments; fishing; hospitals; labor
13 organizations; logging; manufacturing (metals); min-
14 ing; medical and dental practices; medical labora-
15 tories; sanitary services; transportation (local and
16 freight); and warehousing.

17 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**
18 **BOARDS OF TRUSTEES.**

19 “(a) SPONSOR.—The requirements of this subsection
20 are met with respect to an association health plan if the
21 sponsor has met (or is deemed under this part to have
22 met) the requirements of section 801(b) for a continuous
23 period of not less than 3 years ending with the date of
24 the application for certification under this part.

1 “(b) BOARD OF TRUSTEES.—The requirements of
2 this subsection are met with respect to an association
3 health plan if the following requirements are met:

4 “(1) FISCAL CONTROL.—The plan is operated,
5 pursuant to a trust agreement, by a board of trust-
6 ees which has complete fiscal control over the plan
7 and which is responsible for all operations of the
8 plan.

9 “(2) RULES OF OPERATION AND FINANCIAL
10 CONTROLS.—The board of trustees has in effect
11 rules of operation and financial controls, based on a
12 3-year plan of operation, adequate to carry out the
13 terms of the plan and to meet all requirements of
14 this title applicable to the plan.

15 “(3) RULES GOVERNING RELATIONSHIP TO
16 PARTICIPATING EMPLOYERS AND TO CONTRAC-
17 TORS.—

18 “(A) IN GENERAL.—Except as provided in
19 subparagraphs (B) and (C), the members of the
20 board of trustees are individuals selected from
21 individuals who are the owners, officers, direc-
22 tors, or employees of the participating employ-
23 ers or who are partners in the participating em-
24 ployers and actively participate in the business.

25 “(B) LIMITATION.—

1 “(i) GENERAL RULE.—Except as pro-
2 vided in clauses (ii) and (iii), no such
3 member is an owner, officer, director, or
4 employee of, or partner in, a contract ad-
5 ministrator or other service provider to the
6 plan.

7 “(ii) LIMITED EXCEPTION FOR PRO-
8 VIDERS OF SERVICES SOLELY ON BEHALF
9 OF THE SPONSOR.—Officers or employees
10 of a sponsor which is a service provider
11 (other than a contract administrator) to
12 the plan may be members of the board if
13 they constitute not more than 25 percent
14 of the membership of the board and they
15 do not provide services to the plan other
16 than on behalf of the sponsor.

17 “(iii) TREATMENT OF PROVIDERS OF
18 MEDICAL CARE.—In the case of a sponsor
19 which is an association whose membership
20 consists primarily of providers of medical
21 care, clause (i) shall not apply in the case
22 of any service provider described in sub-
23 paragraph (A) who is a provider of medical
24 care under the plan.

1 “(C) CERTAIN PLANS EXCLUDED.—Sub-
2 paragraph (A) shall not apply to an association
3 health plan which is in existence on the date of
4 the enactment of the Patients’ Bill of Rights
5 Act of 2001.

6 “(D) SOLE AUTHORITY.—The board has
7 sole authority under the plan to approve appli-
8 cations for participation in the plan and to con-
9 tract with a service provider to administer the
10 day-to-day affairs of the plan.

11 “(c) TREATMENT OF FRANCHISE NETWORKS.—In
12 the case of a group health plan which is established and
13 maintained by a franchiser for a franchise network con-
14 sisting of its franchisees—

15 “(1) the requirements of subsection (a) and sec-
16 tion 801(a)(1) shall be deemed met if such require-
17 ments would otherwise be met if the franchiser were
18 deemed to be the sponsor referred to in section
19 801(b), such network were deemed to be an associa-
20 tion described in section 801(b), and each franchisee
21 were deemed to be a member (of the association and
22 the sponsor) referred to in section 801(b); and

23 “(2) the requirements of section 804(a)(1) shall
24 be deemed met.

1 The Secretary may by regulation, through negotiated rule-
2 making, define for purposes of this subsection the terms
3 ‘franchiser’, ‘franchise network’, and ‘franchisee’.

4 “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

5 “(1) IN GENERAL.—In the case of a group
6 health plan described in paragraph (2)—

7 “(A) the requirements of subsection (a)
8 and section 801(a)(1) shall be deemed met;

9 “(B) the joint board of trustees shall be
10 deemed a board of trustees with respect to
11 which the requirements of subsection (b) are
12 met; and

13 “(C) the requirements of section 804 shall
14 be deemed met.

15 “(2) REQUIREMENTS.—A group health plan is
16 described in this paragraph if—

17 “(A) the plan is a multiemployer plan; or

18 “(B) the plan is in existence on April 1,
19 2001, and would be described in section
20 3(40)(A)(i) but solely for the failure to meet
21 the requirements of section 3(40)(C)(ii).

22 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**
23 **MENTS.**

24 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The
25 requirements of this subsection are met with respect to

1 an association health plan if, under the terms of the
2 plan—

3 “(1) each participating employer must be—

4 “(A) a member of the sponsor,

5 “(B) the sponsor, or

6 “(C) an affiliated member of the sponsor

7 with respect to which the requirements of sub-

8 section (b) are met,

9 except that, in the case of a sponsor which is a pro-
10 fessional association or other individual-based asso-
11 ciation, if at least one of the officers, directors, or
12 employees of an employer, or at least one of the in-
13 dividuals who are partners in an employer and who
14 actively participates in the business, is a member or
15 such an affiliated member of the sponsor, partici-
16 pating employers may also include such employer;
17 and

18 “(2) all individuals commencing coverage under
19 the plan after certification under this part must
20 be—

21 “(A) active or retired owners (including
22 self-employed individuals), officers, directors, or
23 employees of, or partners in, participating em-
24 ployers; or

1 “(B) the beneficiaries of individuals de-
2 scribed in subparagraph (A).

3 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-
4 PLOYEES.—In the case of an association health plan in
5 existence on the date of the enactment of the Patients’
6 Bill of Rights Act of 2001, an affiliated member of the
7 sponsor of the plan may be offered coverage under the
8 plan as a participating employer only if—

9 “(1) the affiliated member was an affiliated
10 member on the date of certification under this part;
11 or

12 “(2) during the 12-month period preceding the
13 date of the offering of such coverage, the affiliated
14 member has not maintained or contributed to a
15 group health plan with respect to any of its employ-
16 ees who would otherwise be eligible to participate in
17 such association health plan.

18 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-
19 quirements of this subsection are met with respect to an
20 association health plan if, under the terms of the plan,
21 no participating employer may provide health insurance
22 coverage in the individual market for any employee not
23 covered under the plan which is similar to the coverage
24 contemporaneously provided to employees of the employer
25 under the plan, if such exclusion of the employee from cov-

1 erage under the plan is based on a health status-related
2 factor with respect to the employee and such employee
3 would, but for such exclusion on such basis, be eligible
4 for coverage under the plan.

5 “(d) PROHIBITION OF DISCRIMINATION AGAINST
6 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-
7 PATE.—The requirements of this subsection are met with
8 respect to an association health plan if—

9 “(1) under the terms of the plan, all employers
10 meeting the preceding requirements of this section
11 are eligible to qualify as participating employers for
12 all geographically available coverage options, unless,
13 in the case of any such employer, participation or
14 contribution requirements of the type referred to in
15 section 2711 of the Public Health Service Act are
16 not met;

17 “(2) upon request, any employer eligible to par-
18 ticipate is furnished information regarding all cov-
19 erage options available under the plan; and

20 “(3) the applicable requirements of sections
21 701, 702, and 703 are met with respect to the plan.

1 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**
2 **DOCUMENTS, CONTRIBUTION RATES, AND**
3 **BENEFIT OPTIONS.**

4 “(a) IN GENERAL.—The requirements of this section
5 are met with respect to an association health plan if the
6 following requirements are met:

7 “(1) CONTENTS OF GOVERNING INSTRU-
8 MENTS.—The instruments governing the plan in-
9 clude a written instrument, meeting the require-
10 ments of an instrument required under section
11 402(a)(1), which—

12 “(A) provides that the board of trustees
13 serves as the named fiduciary required for plans
14 under section 402(a)(1) and serves in the ca-
15 pacity of a plan administrator (referred to in
16 section 3(16)(A));

17 “(B) provides that the sponsor of the plan
18 is to serve as plan sponsor (referred to in sec-
19 tion 3(16)(B)); and

20 “(C) incorporates the requirements of sec-
21 tion 806.

22 “(2) CONTRIBUTION RATES MUST BE NON-
23 DISCRIMINATORY.—

24 “(A) The contribution rates for any par-
25 ticipating small employer do not vary on the
26 basis of the claims experience of such employer

1 and do not vary on the basis of the type of
2 business or industry in which such employer is
3 engaged.

4 “(B) Nothing in this title or any other pro-
5 vision of law shall be construed to preclude an
6 association health plan, or a health insurance
7 issuer offering health insurance coverage in
8 connection with an association health plan,
9 from—

10 “(i) setting contribution rates based
11 on the claims experience of the plan; or

12 “(ii) varying contribution rates for
13 small employers in a State to the extent
14 that such rates could vary using the same
15 methodology employed in such State for
16 regulating premium rates in the small
17 group market with respect to health insur-
18 ance coverage offered in connection with
19 bona fide associations (within the meaning
20 of section 2791(d)(3) of the Public Health
21 Service Act),

22 subject to the requirements of section 702(b)
23 relating to contribution rates.

24 “(3) FLOOR FOR NUMBER OF COVERED INDI-
25 VIDUALS WITH RESPECT TO CERTAIN PLANS.—If

1 any benefit option under the plan does not consist
2 of health insurance coverage, the plan has as of the
3 beginning of the plan year not fewer than 1,000 par-
4 ticipants and beneficiaries.

5 “(4) MARKETING REQUIREMENTS.—

6 “(A) IN GENERAL.—If a benefit option
7 which consists of health insurance coverage is
8 offered under the plan, State-licensed insurance
9 agents shall be used to distribute to small em-
10 ployers coverage which does not consist of
11 health insurance coverage in a manner com-
12 parable to the manner in which such agents are
13 used to distribute health insurance coverage.

14 “(B) STATE-LICENSED INSURANCE
15 AGENTS.—For purposes of subparagraph (A),
16 the term ‘State-licensed insurance agents’
17 means one or more agents who are licensed in
18 a State and are subject to the laws of such
19 State relating to licensure, qualification, test-
20 ing, examination, and continuing education of
21 persons authorized to offer, sell, or solicit
22 health insurance coverage in such State.

23 “(5) REGULATORY REQUIREMENTS.—Such
24 other requirements as the applicable authority deter-
25 mines are necessary to carry out the purposes of this

1 part, which shall be prescribed by the applicable au-
2 thority by regulation through negotiated rulemaking.

3 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO
4 DESIGN BENEFIT OPTIONS.—Subject to section 514(e),
5 nothing in this part or any provision of State law (as de-
6 fined in section 514(c)(1)) shall be construed to preclude
7 an association health plan, or a health insurance issuer
8 offering health insurance coverage in connection with an
9 association health plan, from exercising its sole discretion
10 in selecting the specific items and services consisting of
11 medical care to be included as benefits under such plan
12 or coverage, except (subject to section 514) in the case
13 of any law to the extent that it (1) prohibits an exclusion
14 of a specific disease from such coverage, or (2) is not pre-
15 empted under section 731(a)(1) with respect to matters
16 governed by section 711 or 712.

17 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**
18 **FOR SOLVENCY FOR PLANS PROVIDING**
19 **HEALTH BENEFITS IN ADDITION TO HEALTH**
20 **INSURANCE COVERAGE.**

21 “(a) IN GENERAL.—The requirements of this section
22 are met with respect to an association health plan if—

23 “(1) the benefits under the plan consist solely
24 of health insurance coverage; or

1 “(2) if the plan provides any additional benefit
2 options which do not consist of health insurance cov-
3 erage, the plan—

4 “(A) establishes and maintains reserves
5 with respect to such additional benefit options,
6 in amounts recommended by the qualified actu-
7 ary, consisting of—

8 “(i) a reserve sufficient for unearned
9 contributions;

10 “(ii) a reserve sufficient for benefit li-
11 abilities which have been incurred, which
12 have not been satisfied, and for which risk
13 of loss has not yet been transferred, and
14 for expected administrative costs with re-
15 spect to such benefit liabilities;

16 “(iii) a reserve sufficient for any other
17 obligations of the plan; and

18 “(iv) a reserve sufficient for a margin
19 of error and other fluctuations, taking into
20 account the specific circumstances of the
21 plan; and

22 “(B) establishes and maintains aggregate
23 and specific excess/stop loss insurance and sol-
24 vency indemnification, with respect to such ad-

1 ditional benefit options for which risk of loss
2 has not yet been transferred, as follows:

3 “(i) The plan shall secure aggregate
4 excess/stop loss insurance for the plan
5 with an attachment point which is not
6 greater than 125 percent of expected gross
7 annual claims. The applicable authority
8 may by regulation, through negotiated
9 rulemaking, provide for upward adjust-
10 ments in the amount of such percentage in
11 specified circumstances in which the plan
12 specifically provides for and maintains re-
13 serves in excess of the amounts required
14 under subparagraph (A).

15 “(ii) The plan shall secure specific ex-
16 cess/stop loss insurance for the plan with
17 an attachment point which is at least equal
18 to an amount recommended by the plan’s
19 qualified actuary. The applicable authority
20 may by regulation, through negotiated
21 rulemaking, provide for adjustments in the
22 amount of such insurance in specified cir-
23 cumstances in which the plan specifically
24 provides for and maintains reserves in ex-

1 cess of the amounts required under sub-
2 paragraph (A).

3 “(iii) The plan shall secure indem-
4 nification insurance for any claims which
5 the plan is unable to satisfy by reason of
6 a plan termination.

7 Any regulations prescribed by the applicable authority
8 pursuant to clause (i) or (ii) of subparagraph (B) may
9 allow for such adjustments in the required levels of excess/
10 stop loss insurance as the qualified actuary may rec-
11 ommend, taking into account the specific circumstances
12 of the plan.

13 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS
14 RESERVES.—In the case of any association health plan de-
15 scribed in subsection (a)(2), the requirements of this sub-
16 section are met if the plan establishes and maintains sur-
17 plus in an amount at least equal to—

18 “(1) \$500,000, or

19 “(2) such greater amount (but not greater than
20 \$2,000,000) as may be set forth in regulations pre-
21 scribed by the applicable authority through nego-
22 tiated rulemaking, based on the level of aggregate
23 and specific excess/stop loss insurance provided with
24 respect to such plan.

1 “(c) **ADDITIONAL REQUIREMENTS.**—In the case of
2 any association health plan described in subsection (a)(2),
3 the applicable authority may provide such additional re-
4 quirements relating to reserves and excess/stop loss insur-
5 ance as the applicable authority considers appropriate.
6 Such requirements may be provided by regulation, through
7 negotiated rulemaking, with respect to any such plan or
8 any class of such plans.

9 “(d) **ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-**
10 **ANCE.**—The applicable authority may provide for adjust-
11 ments to the levels of reserves otherwise required under
12 subsections (a) and (b) with respect to any plan or class
13 of plans to take into account excess/stop loss insurance
14 provided with respect to such plan or plans.

15 “(e) **ALTERNATIVE MEANS OF COMPLIANCE.**—The
16 applicable authority may permit an association health plan
17 described in subsection (a)(2) to substitute, for all or part
18 of the requirements of this section (except subsection
19 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-
20 rangement, or other financial arrangement as the applica-
21 ble authority determines to be adequate to enable the plan
22 to fully meet all its financial obligations on a timely basis
23 and is otherwise no less protective of the interests of par-
24 ticipants and beneficiaries than the requirements for
25 which it is substituted. The applicable authority may take

1 into account, for purposes of this subsection, evidence pro-
2 vided by the plan or sponsor which demonstrates an as-
3 sumption of liability with respect to the plan. Such evi-
4 dence may be in the form of a contract of indemnification,
5 lien, bonding, insurance, letter of credit, recourse under
6 applicable terms of the plan in the form of assessments
7 of participating employers, security, or other financial ar-
8 rangement.

9 “(f) MEASURES TO ENSURE CONTINUED PAYMENT
10 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

11 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-
12 CIATION HEALTH PLAN FUND.—

13 “(A) IN GENERAL.—In the case of an as-
14 sociation health plan described in subsection
15 (a)(2), the requirements of this subsection are
16 met if the plan makes payments into the Asso-
17 ciation Health Plan Fund under this subpara-
18 graph when they are due. Such payments shall
19 consist of annual payments in the amount of
20 \$5,000, and, in addition to such annual pay-
21 ments, such supplemental payments as the Sec-
22 retary may determine to be necessary under
23 paragraph (2). Payments under this paragraph
24 are payable to the Fund at the time determined
25 by the Secretary. Initial payments are due in

1 advance of certification under this part. Pay-
2 ments shall continue to accrue until a plan's as-
3 sets are distributed pursuant to a termination
4 procedure.

5 “(B) PENALTIES FOR FAILURE TO MAKE
6 PAYMENTS.—If any payment is not made by a
7 plan when it is due, a late payment charge of
8 not more than 100 percent of the payment
9 which was not timely paid shall be payable by
10 the plan to the Fund.

11 “(C) CONTINUED DUTY OF THE SEC-
12 RETARY.—The Secretary shall not cease to
13 carry out the provisions of paragraph (2) on ac-
14 count of the failure of a plan to pay any pay-
15 ment when due.

16 “(2) PAYMENTS BY SECRETARY TO CONTINUE
17 EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-
18 DEMNIFICATION INSURANCE COVERAGE FOR CER-
19 TAIN PLANS.—In any case in which the applicable
20 authority determines that there is, or that there is
21 reason to believe that there will be: (A) a failure to
22 take necessary corrective actions under section
23 809(a) with respect to an association health plan de-
24 scribed in subsection (a)(2); or (B) a termination of
25 such a plan under section 809(b) or 810(b)(8) (and,

1 if the applicable authority is not the Secretary, cer-
2 tifies such determination to the Secretary), the Sec-
3 retary shall determine the amounts necessary to
4 make payments to an insurer (designated by the
5 Secretary) to maintain in force excess/stop loss in-
6 surance coverage or indemnification insurance cov-
7 erage for such plan, if the Secretary determines that
8 there is a reasonable expectation that, without such
9 payments, claims would not be satisfied by reason of
10 termination of such coverage. The Secretary shall, to
11 the extent provided in advance in appropriation
12 Acts, pay such amounts so determined to the insurer
13 designated by the Secretary.

14 “(3) ASSOCIATION HEALTH PLAN FUND.—

15 “(A) IN GENERAL.—There is established
16 on the books of the Treasury a fund to be
17 known as the ‘Association Health Plan Fund’.
18 The Fund shall be available for making pay-
19 ments pursuant to paragraph (2). The Fund
20 shall be credited with payments received pursu-
21 ant to paragraph (1)(A), penalties received pur-
22 suant to paragraph (1)(B); and earnings on in-
23 vestments of amounts of the Fund under sub-
24 paragraph (B).

1 “(B) INVESTMENT.—Whenever the Sec-
2 retary determines that the moneys of the fund
3 are in excess of current needs, the Secretary
4 may request the investment of such amounts as
5 the Secretary determines advisable by the Sec-
6 retary of the Treasury in obligations issued or
7 guaranteed by the United States.

8 “(g) EXCESS/STOP LOSS INSURANCE.—For pur-
9 poses of this section—

10 “(1) AGGREGATE EXCESS/STOP LOSS INSUR-
11 ANCE.—The term ‘aggregate excess/stop loss insur-
12 ance’ means, in connection with an association
13 health plan, a contract—

14 “(A) under which an insurer (meeting such
15 minimum standards as the applicable authority
16 may prescribe by regulation through negotiated
17 rulemaking) provides for payment to the plan
18 with respect to aggregate claims under the plan
19 in excess of an amount or amounts specified in
20 such contract;

21 “(B) which is guaranteed renewable; and

22 “(C) which allows for payment of pre-
23 miums by any third party on behalf of the in-
24 sured plan.

1 “(2) SPECIFIC EXCESS/STOP LOSS INSUR-
2 ANCE.—The term ‘specific excess/stop loss insur-
3 ance’ means, in connection with an association
4 health plan, a contract—

5 “(A) under which an insurer (meeting such
6 minimum standards as the applicable authority
7 may prescribe by regulation through negotiated
8 rulemaking) provides for payment to the plan
9 with respect to claims under the plan in connec-
10 tion with a covered individual in excess of an
11 amount or amounts specified in such contract
12 in connection with such covered individual;

13 “(B) which is guaranteed renewable; and

14 “(C) which allows for payment of pre-
15 miums by any third party on behalf of the in-
16 sured plan.

17 “(h) INDEMNIFICATION INSURANCE.—For purposes
18 of this section, the term ‘indemnification insurance’
19 means, in connection with an association health plan, a
20 contract—

21 “(1) under which an insurer (meeting such min-
22 imum standards as the applicable authority may pre-
23 scribe through negotiated rulemaking) provides for
24 payment to the plan with respect to claims under the
25 plan which the plan is unable to satisfy by reason

1 of a termination pursuant to section 809(b) (relating
2 to mandatory termination);

3 “(2) which is guaranteed renewable and
4 noncancellable for any reason (except as the applica-
5 ble authority may prescribe by regulation through
6 negotiated rulemaking); and

7 “(3) which allows for payment of premiums by
8 any third party on behalf of the insured plan.

9 “(i) RESERVES.—For purposes of this section, the
10 term ‘reserves’ means, in connection with an association
11 health plan, plan assets which meet the fiduciary stand-
12 ards under part 4 and such additional requirements re-
13 garding liquidity as the applicable authority may prescribe
14 through negotiated rulemaking.

15 “(j) SOLVENCY STANDARDS WORKING GROUP.—

16 “(1) IN GENERAL.—Within 90 days after the
17 date of the enactment of the Patients’ Bill of Rights
18 Act of 2001, the applicable authority shall establish
19 a Solvency Standards Working Group. In prescribing
20 the initial regulations under this section, the applica-
21 ble authority shall take into account the rec-
22 ommendations of such Working Group.

23 “(2) MEMBERSHIP.—The Working Group shall
24 consist of not more than 15 members appointed by
25 the applicable authority. The applicable authority

1 shall include among persons invited to membership
2 on the Working Group at least one of each of the
3 following:

4 “(A) a representative of the National Asso-
5 ciation of Insurance Commissioners;

6 “(B) a representative of the American
7 Academy of Actuaries;

8 “(C) a representative of the State govern-
9 ments, or their interests;

10 “(D) a representative of existing self-in-
11 sured arrangements, or their interests;

12 “(E) a representative of associations of the
13 type referred to in section 801(b)(1), or their
14 interests; and

15 “(F) a representative of multiemployer
16 plans that are group health plans, or their in-
17 terests.

18 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RE-**
19 **LATED REQUIREMENTS.**

20 “(a) **FILING FEE.**—Under the procedure prescribed
21 pursuant to section 802(a), an association health plan
22 shall pay to the applicable authority at the time of filing
23 an application for certification under this part a filing fee
24 in the amount of \$5,000, which shall be available in the
25 case of the Secretary, to the extent provided in appropria-

1 tion Acts, for the sole purpose of administering the certifi-
2 cation procedures applicable with respect to association
3 health plans.

4 “(b) INFORMATION TO BE INCLUDED IN APPLICA-
5 TION FOR CERTIFICATION.—An application for certifi-
6 cation under this part meets the requirements of this sec-
7 tion only if it includes, in a manner and form which shall
8 be prescribed by the applicable authority through nego-
9 tiated rulemaking, at least the following information:

10 “(1) IDENTIFYING INFORMATION.—The names
11 and addresses of—

12 “(A) the sponsor; and

13 “(B) the members of the board of trustees
14 of the plan.

15 “(2) STATES IN WHICH PLAN INTENDS TO DO
16 BUSINESS.—The States in which participants and
17 beneficiaries under the plan are to be located and
18 the number of them expected to be located in each
19 such State.

20 “(3) BONDING REQUIREMENTS.—Evidence pro-
21 vided by the board of trustees that the bonding re-
22 quirements of section 412 will be met as of the date
23 of the application or (if later) commencement of op-
24 erations.

1 “(4) PLAN DOCUMENTS.—A copy of the docu-
2 ments governing the plan (including any bylaws and
3 trust agreements), the summary plan description,
4 and other material describing the benefits that will
5 be provided to participants and beneficiaries under
6 the plan.

7 “(5) AGREEMENTS WITH SERVICE PRO-
8 VIDERS.—A copy of any agreements between the
9 plan and contract administrators and other service
10 providers.

11 “(6) FUNDING REPORT.—In the case of asso-
12 ciation health plans providing benefits options in ad-
13 dition to health insurance coverage, a report setting
14 forth information with respect to such additional
15 benefit options determined as of a date within the
16 120-day period ending with the date of the applica-
17 tion, including the following:

18 “(A) RESERVES.—A statement, certified
19 by the board of trustees of the plan, and a
20 statement of actuarial opinion, signed by a
21 qualified actuary, that all applicable require-
22 ments of section 806 are or will be met in ac-
23 cordance with regulations which the applicable
24 authority shall prescribe through negotiated
25 rulemaking.

1 “(B) ADEQUACY OF CONTRIBUTION
2 RATES.—A statement of actuarial opinion,
3 signed by a qualified actuary, which sets forth
4 a description of the extent to which contribution
5 rates are adequate to provide for the payment
6 of all obligations and the maintenance of re-
7 quired reserves under the plan for the 12-
8 month period beginning with such date within
9 such 120-day period, taking into account the
10 expected coverage and experience of the plan. If
11 the contribution rates are not fully adequate,
12 the statement of actuarial opinion shall indicate
13 the extent to which the rates are inadequate
14 and the changes needed to ensure adequacy.

15 “(C) CURRENT AND PROJECTED VALUE OF
16 ASSETS AND LIABILITIES.—A statement of ac-
17 tuarial opinion signed by a qualified actuary,
18 which sets forth the current value of the assets
19 and liabilities accumulated under the plan and
20 a projection of the assets, liabilities, income,
21 and expenses of the plan for the 12-month pe-
22 riod referred to in subparagraph (B). The in-
23 come statement shall identify separately the
24 plan’s administrative expenses and claims.

1 “(D) COSTS OF COVERAGE TO BE
2 CHARGED AND OTHER EXPENSES.—A state-
3 ment of the costs of coverage to be charged, in-
4 cluding an itemization of amounts for adminis-
5 tration, reserves, and other expenses associated
6 with the operation of the plan.

7 “(E) OTHER INFORMATION.—Any other
8 information as may be determined by the appli-
9 cable authority, by regulation through nego-
10 tiated rulemaking, as necessary to carry out the
11 purposes of this part.

12 “(c) FILING NOTICE OF CERTIFICATION WITH
13 STATES.—A certification granted under this part to an
14 association health plan shall not be effective unless written
15 notice of such certification is filed with the applicable
16 State authority of each State in which at least 25 percent
17 of the participants and beneficiaries under the plan are
18 located. For purposes of this subsection, an individual
19 shall be considered to be located in the State in which a
20 known address of such individual is located or in which
21 such individual is employed.

22 “(d) NOTICE OF MATERIAL CHANGES.—In the case
23 of any association health plan certified under this part,
24 descriptions of material changes in any information which
25 was required to be submitted with the application for the

1 certification under this part shall be filed in such form
2 and manner as shall be prescribed by the applicable au-
3 thority by regulation through negotiated rulemaking. The
4 applicable authority may require by regulation, through
5 negotiated rulemaking, prior notice of material changes
6 with respect to specified matters which might serve as the
7 basis for suspension or revocation of the certification.

8 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-
9 SOCIATION HEALTH PLANS.—An association health plan
10 certified under this part which provides benefit options in
11 addition to health insurance coverage for such plan year
12 shall meet the requirements of section 103 by filing an
13 annual report under such section which shall include infor-
14 mation described in subsection (b)(6) with respect to the
15 plan year and, notwithstanding section 104(a)(1)(A), shall
16 be filed with the applicable authority not later than 90
17 days after the close of the plan year (or on such later date
18 as may be prescribed by the applicable authority). The ap-
19 plicable authority may require by regulation through nego-
20 tiated rulemaking such interim reports as it considers ap-
21 propriate.

22 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The
23 board of trustees of each association health plan which
24 provides benefits options in addition to health insurance
25 coverage and which is applying for certification under this

1 part or is certified under this part shall engage, on behalf
2 of all participants and beneficiaries, a qualified actuary
3 who shall be responsible for the preparation of the mate-
4 rials comprising information necessary to be submitted by
5 a qualified actuary under this part. The qualified actuary
6 shall utilize such assumptions and techniques as are nec-
7 essary to enable such actuary to form an opinion as to
8 whether the contents of the matters reported under this
9 part—

10 “(1) are in the aggregate reasonably related to
11 the experience of the plan and to reasonable expecta-
12 tions; and

13 “(2) represent such actuary’s best estimate of
14 anticipated experience under the plan.

15 The opinion by the qualified actuary shall be made with
16 respect to, and shall be made a part of, the annual report.

17 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**
18 **MINATION.**

19 “Except as provided in section 809(b), an association
20 health plan which is or has been certified under this part
21 may terminate (upon or at any time after cessation of ac-
22 cruals in benefit liabilities) only if the board of trustees—

23 “(1) not less than 60 days before the proposed
24 termination date, provides to the participants and
25 beneficiaries a written notice of intent to terminate

1 stating that such termination is intended and the
2 proposed termination date;

3 “(2) develops a plan for winding up the affairs
4 of the plan in connection with such termination in
5 a manner which will result in timely payment of all
6 benefits for which the plan is obligated; and

7 “(3) submits such plan in writing to the appli-
8 cable authority.

9 Actions required under this section shall be taken in such
10 form and manner as may be prescribed by the applicable
11 authority by regulation through negotiated rulemaking.

12 **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-
13 NATION.**

14 “(a) ACTIONS TO AVOID DEPLETION OF RE-
15 SERVES.—An association health plan which is certified
16 under this part and which provides benefits other than
17 health insurance coverage shall continue to meet the re-
18 quirements of section 806, irrespective of whether such
19 certification continues in effect. The board of trustees of
20 such plan shall determine quarterly whether the require-
21 ments of section 806 are met. In any case in which the
22 board determines that there is reason to believe that there
23 is or will be a failure to meet such requirements, or the
24 applicable authority makes such a determination and so
25 notifies the board, the board shall immediately notify the

1 qualified actuary engaged by the plan, and such actuary
2 shall, not later than the end of the next following month,
3 make such recommendations to the board for corrective
4 action as the actuary determines necessary to ensure com-
5 pliance with section 806. Not later than 30 days after re-
6 ceiving from the actuary recommendations for corrective
7 actions, the board shall notify the applicable authority (in
8 such form and manner as the applicable authority may
9 prescribe by regulation through negotiated rulemaking) of
10 such recommendations of the actuary for corrective action,
11 together with a description of the actions (if any) that the
12 board has taken or plans to take in response to such rec-
13 ommendations. The board shall thereafter report to the
14 applicable authority, in such form and frequency as the
15 applicable authority may specify to the board, regarding
16 corrective action taken by the board until the requirements
17 of section 806 are met.

18 “(b) MANDATORY TERMINATION.—In any case in
19 which—

20 “(1) the applicable authority has been notified
21 under subsection (a) of a failure of an association
22 health plan which is or has been certified under this
23 part and is described in section 806(a)(2) to meet
24 the requirements of section 806 and has not been
25 notified by the board of trustees of the plan that

1 corrective action has restored compliance with such
2 requirements; and

3 “(2) the applicable authority determines that
4 there is a reasonable expectation that the plan will
5 continue to fail to meet the requirements of section
6 806,

7 the board of trustees of the plan shall, at the direction
8 of the applicable authority, terminate the plan and, in the
9 course of the termination, take such actions as the appli-
10 cable authority may require, including satisfying any
11 claims referred to in section 806(a)(2)(B)(iii) and recov-
12 ering for the plan any liability under subsection
13 (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure
14 that the affairs of the plan will be, to the maximum extent
15 possible, wound up in a manner which will result in timely
16 provision of all benefits for which the plan is obligated.

17 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**
18 **VENT ASSOCIATION HEALTH PLANS PRO-**
19 **VIDING HEALTH BENEFITS IN ADDITION TO**
20 **HEALTH INSURANCE COVERAGE.**

21 “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
22 INSOLVENT PLANS.—Whenever the Secretary determines
23 that an association health plan which is or has been cer-
24 tified under this part and which is described in section
25 806(a)(2) will be unable to provide benefits when due or

1 is otherwise in a financially hazardous condition, as shall
2 be defined by the Secretary by regulation through nego-
3 tiated rulemaking, the Secretary shall, upon notice to the
4 plan, apply to the appropriate United States district court
5 for appointment of the Secretary as trustee to administer
6 the plan for the duration of the insolvency. The plan may
7 appear as a party and other interested persons may inter-
8 vene in the proceedings at the discretion of the court. The
9 court shall appoint such Secretary trustee if the court de-
10 termines that the trusteeship is necessary to protect the
11 interests of the participants and beneficiaries or providers
12 of medical care or to avoid any unreasonable deterioration
13 of the financial condition of the plan. The trusteeship of
14 such Secretary shall continue until the conditions de-
15 scribed in the first sentence of this subsection are rem-
16 edied or the plan is terminated.

17 “(b) POWERS AS TRUSTEE.—The Secretary, upon
18 appointment as trustee under subsection (a), shall have
19 the power—

20 “(1) to do any act authorized by the plan, this
21 title, or other applicable provisions of law to be done
22 by the plan administrator or any trustee of the plan;

23 “(2) to require the transfer of all (or any part)
24 of the assets and records of the plan to the Sec-
25 retary as trustee;

1 “(3) to invest any assets of the plan which the
2 Secretary holds in accordance with the provisions of
3 the plan, regulations prescribed by the Secretary
4 through negotiated rulemaking, and applicable provi-
5 sions of law;

6 “(4) to require the sponsor, the plan adminis-
7 trator, any participating employer, and any employee
8 organization representing plan participants to fur-
9 nish any information with respect to the plan which
10 the Secretary as trustee may reasonably need in
11 order to administer the plan;

12 “(5) to collect for the plan any amounts due the
13 plan and to recover reasonable expenses of the trust-
14 eeship;

15 “(6) to commence, prosecute, or defend on be-
16 half of the plan any suit or proceeding involving the
17 plan;

18 “(7) to issue, publish, or file such notices, state-
19 ments, and reports as may be required by the Sec-
20 retary by regulation through negotiated rulemaking
21 or required by any order of the court;

22 “(8) to terminate the plan (or provide for its
23 termination in accordance with section 809(b)) and
24 liquidate the plan assets, to restore the plan to the

1 responsibility of the sponsor, or to continue the
2 trusteeship;

3 “(9) to provide for the enrollment of plan par-
4 ticipants and beneficiaries under appropriate cov-
5 erage options; and

6 “(10) to do such other acts as may be nec-
7 essary to comply with this title or any order of the
8 court and to protect the interests of plan partici-
9 pants and beneficiaries and providers of medical
10 care.

11 “(c) NOTICE OF APPOINTMENT.—As soon as prac-
12 ticable after the Secretary’s appointment as trustee, the
13 Secretary shall give notice of such appointment to—

14 “(1) the sponsor and plan administrator;

15 “(2) each participant;

16 “(3) each participating employer; and

17 “(4) if applicable, each employee organization
18 which, for purposes of collective bargaining, rep-
19 resents plan participants.

20 “(d) ADDITIONAL DUTIES.—Except to the extent in-
21 consistent with the provisions of this title, or as may be
22 otherwise ordered by the court, the Secretary, upon ap-
23 pointment as trustee under this section, shall be subject
24 to the same duties as those of a trustee under section 704

1 of title 11, United States Code, and shall have the duties
2 of a fiduciary for purposes of this title.

3 “(e) OTHER PROCEEDINGS.—An application by the
4 Secretary under this subsection may be filed notwith-
5 standing the pendency in the same or any other court of
6 any bankruptcy, mortgage foreclosure, or equity receiver-
7 ship proceeding, or any proceeding to reorganize, conserve,
8 or liquidate such plan or its property, or any proceeding
9 to enforce a lien against property of the plan.

10 “(f) JURISDICTION OF COURT.—

11 “(1) IN GENERAL.—Upon the filing of an appli-
12 cation for the appointment as trustee or the issuance
13 of a decree under this section, the court to which the
14 application is made shall have exclusive jurisdiction
15 of the plan involved and its property wherever lo-
16 cated with the powers, to the extent consistent with
17 the purposes of this section, of a court of the United
18 States having jurisdiction over cases under chapter
19 11 of title 11, United States Code. Pending an adju-
20 dication under this section such court shall stay, and
21 upon appointment by it of the Secretary as trustee,
22 such court shall continue the stay of, any pending
23 mortgage foreclosure, equity receivership, or other
24 proceeding to reorganize, conserve, or liquidate the
25 plan, the sponsor, or property of such plan or spon-

1 sor, and any other suit against any receiver, conser-
2 vator, or trustee of the plan, the sponsor, or prop-
3 erty of the plan or sponsor. Pending such adjudica-
4 tion and upon the appointment by it of the Sec-
5 retary as trustee, the court may stay any proceeding
6 to enforce a lien against property of the plan or the
7 sponsor or any other suit against the plan or the
8 sponsor.

9 “(2) VENUE.—An action under this section
10 may be brought in the judicial district where the
11 sponsor or the plan administrator resides or does
12 business or where any asset of the plan is situated.
13 A district court in which such action is brought may
14 issue process with respect to such action in any
15 other judicial district.

16 “(g) PERSONNEL.—In accordance with regulations
17 which shall be prescribed by the Secretary through nego-
18 tiated rulemaking, the Secretary shall appoint, retain, and
19 compensate accountants, actuaries, and other professional
20 service personnel as may be necessary in connection with
21 the Secretary’s service as trustee under this section.

22 **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

23 “(a) IN GENERAL.—Notwithstanding section 514, a
24 State may impose by law a contribution tax on an associa-
25 tion health plan described in section 806(a)(2), if the plan

1 commenced operations in such State after the date of the
2 enactment of the Patients' Bill of Rights Act of 2001.

3 “(b) CONTRIBUTION TAX.—For purposes of this sec-
4 tion, the term ‘contribution tax’ imposed by a State on
5 an association health plan means any tax imposed by such
6 State if—

7 “(1) such tax is computed by applying a rate to
8 the amount of premiums or contributions, with re-
9 spect to individuals covered under the plan who are
10 residents of such State, which are received by the
11 plan from participating employers located in such
12 State or from such individuals;

13 “(2) the rate of such tax does not exceed the
14 rate of any tax imposed by such State on premiums
15 or contributions received by insurers or health main-
16 tenance organizations for health insurance coverage
17 offered in such State in connection with a group
18 health plan;

19 “(3) such tax is otherwise nondiscriminatory;
20 and

21 “(4) the amount of any such tax assessed on
22 the plan is reduced by the amount of any tax or as-
23 sessment otherwise imposed by the State on pre-
24 miums, contributions, or both received by insurers or
25 health maintenance organizations for health insur-

1 ance coverage, aggregate excess/stop loss insurance
2 (as defined in section 806(g)(1)), specific excess/
3 stop loss insurance (as defined in section 806(g)(2)),
4 other insurance related to the provision of medical
5 care under the plan, or any combination thereof pro-
6 vided by such insurers or health maintenance organi-
7 zations in such State in connection with such plan.

8 **“SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.**

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

10 “(1) GROUP HEALTH PLAN.—The term ‘group
11 health plan’ has the meaning provided in section
12 733(a)(1) (after applying subsection (b) of this sec-
13 tion).

14 “(2) MEDICAL CARE.—The term ‘medical care’
15 has the meaning provided in section 733(a)(2).

16 “(3) HEALTH INSURANCE COVERAGE.—The
17 term ‘health insurance coverage’ has the meaning
18 provided in section 733(b)(1).

19 “(4) HEALTH INSURANCE ISSUER.—The term
20 ‘health insurance issuer’ has the meaning provided
21 in section 733(b)(2).

22 “(5) APPLICABLE AUTHORITY.—

23 “(A) IN GENERAL.—Except as provided in
24 subparagraph (B), the term ‘applicable author-

1 ity’ means, in connection with an association
2 health plan—

3 “(i) the State recognized pursuant to
4 subsection (c) of section 506 as the State
5 to which authority has been delegated in
6 connection with such plan; or

7 “(ii) if there if no State referred to in
8 clause (i), the Secretary.

9 “(B) EXCEPTIONS.—

10 “(i) JOINT AUTHORITIES.—Where
11 such term appears in section 808(3), sec-
12 tion 807(e) (in the first instance), section
13 809(a) (in the second instance), section
14 809(a) (in the fourth instance), and sec-
15 tion 809(b)(1), such term means, in con-
16 nection with an association health plan, the
17 Secretary and the State referred to in sub-
18 paragraph (A)(i) (if any) in connection
19 with such plan.

20 “(ii) REGULATORY AUTHORITIES.—
21 Where such term appears in section 802(a)
22 (in the first instance), section 802(d), sec-
23 tion 802(e), section 803(d), section
24 805(a)(5), section 806(a)(2), section
25 806(b), section 806(c), section 806(d),

1 paragraphs (1)(A) and (2)(A) of section
2 806(g), section 806(h), section 806(i), sec-
3 tion 806(j), section 807(a) (in the second
4 instance), section 807(b), section 807(d),
5 section 807(e) (in the second instance),
6 section 808 (in the matter after paragraph
7 (3)), and section 809(a) (in the third in-
8 stance), such term means, in connection
9 with an association health plan, the Sec-
10 retary.

11 “(6) HEALTH STATUS-RELATED FACTOR.—The
12 term ‘health status-related factor’ has the meaning
13 provided in section 733(d)(2).

14 “(7) INDIVIDUAL MARKET.—

15 “(A) IN GENERAL.—The term ‘individual
16 market’ means the market for health insurance
17 coverage offered to individuals other than in
18 connection with a group health plan.

19 “(B) TREATMENT OF VERY SMALL
20 GROUPS.—

21 “(i) IN GENERAL.—Subject to clause
22 (ii), such term includes coverage offered in
23 connection with a group health plan that
24 has fewer than 2 participants as current
25 employees or participants described in sec-

1 tion 732(d)(3) on the first day of the plan
2 year.

3 “(ii) STATE EXCEPTION.—Clause (i)
4 shall not apply in the case of health insur-
5 ance coverage offered in a State if such
6 State regulates the coverage described in
7 such clause in the same manner and to the
8 same extent as coverage in the small group
9 market (as defined in section 2791(e)(5) of
10 the Public Health Service Act) is regulated
11 by such State.

12 “(8) PARTICIPATING EMPLOYER.—The term
13 ‘participating employer’ means, in connection with
14 an association health plan, any employer, if any indi-
15 vidual who is an employee of such employer, a part-
16 ner in such employer, or a self-employed individual
17 who is such employer (or any dependent, as defined
18 under the terms of the plan, of such individual) is
19 or was covered under such plan in connection with
20 the status of such individual as such an employee,
21 partner, or self-employed individual in relation to the
22 plan.

23 “(9) APPLICABLE STATE AUTHORITY.—The
24 term ‘applicable State authority’ means, with respect
25 to a health insurance issuer in a State, the State in-

1 insurance commissioner or official or officials des-
2 ignated by the State to enforce the requirements of
3 title XXVII of the Public Health Service Act for the
4 State involved with respect to such issuer.

5 “(10) QUALIFIED ACTUARY.—The term ‘quali-
6 fied actuary’ means an individual who is a member
7 of the American Academy of Actuaries or meets
8 such reasonable standards and qualifications as the
9 Secretary may provide by regulation through nego-
10 tiated rulemaking.

11 “(11) AFFILIATED MEMBER.—The term ‘affili-
12 ated member’ means, in connection with a sponsor—

13 “(A) a person who is otherwise eligible to
14 be a member of the sponsor but who elects an
15 affiliated status with the sponsor,

16 “(B) in the case of a sponsor with mem-
17 bers which consist of associations, a person who
18 is a member of any such association and elects
19 an affiliated status with the sponsor, or

20 “(C) in the case of an association health
21 plan in existence on the date of the enactment
22 of the Patients’ Bill of Rights Act of 2001, a
23 person eligible to be a member of the sponsor
24 or one of its member associations.

1 “(12) LARGE EMPLOYER.—The term ‘large em-
2 ployer’ means, in connection with a group health
3 plan with respect to a plan year, an employer who
4 employed an average of at least 51 employees on
5 business days during the preceding calendar year
6 and who employs at least 2 employees on the first
7 day of the plan year.

8 “(13) SMALL EMPLOYER.—The term ‘small em-
9 ployer’ means, in connection with a group health
10 plan with respect to a plan year, an employer who
11 is not a large employer.

12 “(b) RULES OF CONSTRUCTION.—

13 “(1) EMPLOYERS AND EMPLOYEES.—For pur-
14 poses of determining whether a plan, fund, or pro-
15 gram is an employee welfare benefit plan which is an
16 association health plan, and for purposes of applying
17 this title in connection with such plan, fund, or pro-
18 gram so determined to be such an employee welfare
19 benefit plan—

20 “(A) in the case of a partnership, the term
21 ‘employer’ (as defined in section 3(5)) includes
22 the partnership in relation to the partners, and
23 the term ‘employee’ (as defined in section 3(6))
24 includes any partner in relation to the partner-
25 ship; and

1 “(B) in the case of a self-employed indi-
2 vidual, the term ‘employer’ (as defined in sec-
3 tion 3(5)) and the term ‘employee’ (as defined
4 in section 3(6)) shall include such individual.

5 “(2) PLANS, FUNDS, AND PROGRAMS TREATED
6 AS EMPLOYEE WELFARE BENEFIT PLANS.—In the
7 case of any plan, fund, or program which was estab-
8 lished or is maintained for the purpose of providing
9 medical care (through the purchase of insurance or
10 otherwise) for employees (or their dependents) cov-
11 ered thereunder and which demonstrates to the Sec-
12 retary that all requirements for certification under
13 this part would be met with respect to such plan,
14 fund, or program if such plan, fund, or program
15 were a group health plan, such plan, fund, or pro-
16 gram shall be treated for purposes of this title as an
17 employee welfare benefit plan on and after the date
18 of such demonstration.”.

19 (b) CONFORMING AMENDMENTS TO PREEMPTION
20 RULES.—

21 (1) Section 514(b)(6) of such Act (29 U.S.C.
22 1144(b)(6)) is amended by adding at the end the
23 following new subparagraph:

24 “(E) The preceding subparagraphs of this paragraph
25 do not apply with respect to any State law in the case

1 of an association health plan which is certified under part
2 8.”.

3 (2) Section 514 of such Act (29 U.S.C. 1144),
4 as amended by section 142, is amended—

5 (A) in subsection (b)(4), by striking “Sub-
6 section (a)” and inserting “Subsections (a) and
7 (e)”;

8 (B) in subsection (b)(5), by striking “sub-
9 section (a)” in subparagraph (A) and inserting
10 “subsection (a) of this section and subsections
11 (a)(2)(B) and (b) of section 805”, and by strik-
12 ing “subsection (a)” in subparagraph (B) and
13 inserting “subsection (a) of this section or sub-
14 section (a)(2)(B) or (b) of section 805”;

15 (C) by redesignating subsection (e) as sub-
16 section (f); and

17 (D) by inserting after subsection (d) the
18 following new subsection:

19 “(e)(1) Except as provided in subsection (b)(4), the
20 provisions of this title shall supersede any and all State
21 laws insofar as they may now or hereafter preclude, or
22 have the effect of precluding, a health insurance issuer
23 from offering health insurance coverage in connection with
24 an association health plan which is certified under part
25 8.

1 “(2) Except as provided in paragraphs (4) and (5)
2 of subsection (b) of this section—

3 “(A) In any case in which health insurance cov-
4 erage of any policy type is offered under an associa-
5 tion health plan certified under part 8 to a partici-
6 pating employer operating in such State, the provi-
7 sions of this title shall supersede any and all laws
8 of such State insofar as they may preclude a health
9 insurance issuer from offering health insurance cov-
10 erage of the same policy type to other employers op-
11 erating in the State which are eligible for coverage
12 under such association health plan, whether or not
13 such other employers are participating employers in
14 such plan.

15 “(B) In any case in which health insurance cov-
16 erage of any policy type is offered under an associa-
17 tion health plan in a State and the filing, with the
18 applicable State authority, of the policy form in con-
19 nection with such policy type is approved by such
20 State authority, the provisions of this title shall su-
21 persede any and all laws of any other State in which
22 health insurance coverage of such type is offered, in-
23 sofar as they may preclude, upon the filing in the
24 same form and manner of such policy form with the

1 applicable State authority in such other State, the
2 approval of the filing in such other State.

3 “(3) For additional provisions relating to association
4 health plans, see subsections (a)(2)(B) and (b) of section
5 805.

6 “(4) For purposes of this subsection, the term ‘asso-
7 ciation health plan’ has the meaning provided in section
8 801(a), and the terms ‘health insurance coverage’, ‘par-
9 ticipating employer’, and ‘health insurance issuer’ have
10 the meanings provided such terms in section 811, respec-
11 tively.”.

12 (3) Section 514(b)(6)(A) of such Act (29
13 U.S.C. 1144(b)(6)(A)) is amended—

14 (A) in clause (i)(II), by striking “and” at
15 the end;

16 (B) in clause (ii), by inserting “and which
17 does not provide medical care (within the mean-
18 ing of section 733(a)(2)),” after “arrange-
19 ment,” and by striking “title.” and inserting
20 “title, and”; and

21 (C) by adding at the end the following new
22 clause:

23 “(iii) subject to subparagraph (E), in the case
24 of any other employee welfare benefit plan which is
25 a multiple employer welfare arrangement and which

1 provides medical care (within the meaning of section
2 733(a)(2)), any law of any State which regulates in-
3 surance may apply.”.

4 (4) Section 514(e) of such Act (as redesignated
5 by paragraph (2)(C)) is amended—

6 (A) by striking “Nothing” and inserting
7 “(1) Except as provided in paragraph (2), noth-
8 ing”; and

9 (B) by adding at the end the following new
10 paragraph:

11 “(2) Nothing in any other provision of law enacted
12 on or after the date of the enactment of the Patients’ Bill
13 of Rights Act of 2001 shall be construed to alter, amend,
14 modify, invalidate, impair, or supersede any provision of
15 this title, except by specific cross-reference to the affected
16 section.”.

17 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act
18 (29 U.S.C. 102(16)(B)) is amended by adding at the end
19 the following new sentence: “Such term also includes a
20 person serving as the sponsor of an association health plan
21 under part 8.”.

22 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-
23 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS
24 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)
25 of such Act (29 U.S.C. 102(b)) is amended by adding at

1 the end the following: “An association health plan shall
 2 include in its summary plan description, in connection
 3 with each benefit option, a description of the form of sol-
 4 vency or guarantee fund protection secured pursuant to
 5 this Act or applicable State law, if any.”.

6 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is
 7 amended by inserting “or part 8” after “this part”.

8 (f) REPORT TO THE CONGRESS REGARDING CERTIFI-
 9 CATION OF SELF-INSURED ASSOCIATION HEALTH
 10 PLANS.—Not later than January 1, 2006, the Secretary
 11 of Labor shall report to the Committee on Education and
 12 the Workforce of the House of Representatives and the
 13 Committee on Health, Education, Labor, and Pensions of
 14 the Senate the effect association health plans have had,
 15 if any, on reducing the number of uninsured individuals.

16 (g) CLERICAL AMENDMENT.—The table of contents
 17 in section 1 of the Employee Retirement Income Security
 18 Act of 1974 is amended by inserting after the item relat-
 19 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates,
 and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans pro-
 viding health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“Sec. 811. State assessment authority.

“Sec. 812. Definitions and rules of construction.”.

1 **SEC. 622. CLARIFICATION OF TREATMENT OF SINGLE EM-**
2 **PLOYER ARRANGEMENTS.**

3 Section 3(40)(B) of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is
5 amended—

6 (1) in clause (i), by inserting “for any plan year
7 of any such plan, or any fiscal year of any such
8 other arrangement;” after “single employer”, and by
9 inserting “during such year or at any time during
10 the preceding 1-year period” after “control group”;

11 (2) in clause (iii)—

12 (A) by striking “common control shall not
13 be based on an interest of less than 25 percent”
14 and inserting “an interest of greater than 25
15 percent may not be required as the minimum
16 interest necessary for common control”; and

17 (B) by striking “similar to” and inserting
18 “consistent and coextensive with”;

19 (3) by redesignating clauses (iv) and (v) as
20 clauses (v) and (vi), respectively; and

21 (4) by inserting after clause (iii) the following
22 new clause:

1 “(iv) in determining, after the application of
2 clause (i), whether benefits are provided to employ-
3 ees of two or more employers, the arrangement shall
4 be treated as having only one participating employer
5 if, after the application of clause (i), the number of
6 individuals who are employees and former employees
7 of any one participating employer and who are cov-
8 ered under the arrangement is greater than 75 per-
9 cent of the aggregate number of all individuals who
10 are employees or former employees of participating
11 employers and who are covered under the arrange-
12 ment;”.

13 **SEC. 623. CLARIFICATION OF TREATMENT OF CERTAIN**
14 **COLLECTIVELY BARGAINED ARRANGE-**
15 **MENTS.**

16 (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-
17 ployee Retirement Income Security Act of 1974 (29
18 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

19 “(i)(I) under or pursuant to one or more collec-
20 tive bargaining agreements which are reached pursu-
21 ant to collective bargaining described in section 8(d)
22 of the National Labor Relations Act (29 U.S.C.
23 158(d)) or paragraph Fourth of section 2 of the
24 Railway Labor Act (45 U.S.C. 152, paragraph
25 Fourth) or which are reached pursuant to labor-

1 management negotiations under similar provisions of
2 State public employee relations laws, and (II) in ac-
3 cordance with subparagraphs (C), (D), and (E);”.

4 (b) LIMITATIONS.—Section 3(40) of such Act (29
5 U.S.C. 1002(40)) is amended by adding at the end the
6 following new subparagraphs:

7 “(C) For purposes of subparagraph (A)(i)(II), a plan
8 or other arrangement shall be treated as established or
9 maintained in accordance with this subparagraph only if
10 the following requirements are met:

11 “(i) The plan or other arrangement, and the
12 employee organization or any other entity sponsoring
13 the plan or other arrangement, do not—

14 “(I) utilize the services of any licensed in-
15 surance agent or broker for soliciting or enroll-
16 ing employers or individuals as participating
17 employers or covered individuals under the plan
18 or other arrangement; or

19 “(II) pay any type of compensation to a
20 person, other than a full time employee of the
21 employee organization (or a member of the or-
22 ganization to the extent provided in regulations
23 prescribed by the Secretary through negotiated
24 rulemaking), that is related either to the volume
25 or number of employers or individuals solicited

1 or enrolled as participating employers or cov-
2 ered individuals under the plan or other ar-
3 rangement, or to the dollar amount or size of
4 the contributions made by participating employ-
5 ers or covered individuals to the plan or other
6 arrangement;

7 except to the extent that the services used by the
8 plan, arrangement, organization, or other entity con-
9 sist solely of preparation of documents necessary for
10 compliance with the reporting and disclosure re-
11 quirements of part 1 or administrative, investment,
12 or consulting services unrelated to solicitation or en-
13 rollment of covered individuals.

14 “(ii) As of the end of the preceding plan year,
15 the number of covered individuals under the plan or
16 other arrangement who are neither—

17 “(I) employed within a bargaining unit
18 covered by any of the collective bargaining
19 agreements with a participating employer (nor
20 covered on the basis of an individual’s employ-
21 ment in such a bargaining unit); nor

22 “(II) present employees (or former employ-
23 ees who were covered while employed) of the
24 sponsoring employee organization, of an em-
25 ployer who is or was a party to any of the col-

1 lective bargaining agreements, or of the plan or
2 other arrangement or a related plan or arrange-
3 ment (nor covered on the basis of such present
4 or former employment);

5 does not exceed 15 percent of the total number of
6 individuals who are covered under the plan or ar-
7 rangement and who are present or former employees
8 who are or were covered under the plan or arrange-
9 ment pursuant to a collective bargaining agreement
10 with a participating employer. The requirements of
11 the preceding provisions of this clause shall be treat-
12 ed as satisfied if, as of the end of the preceding plan
13 year, such covered individuals are comprised solely
14 of individuals who were covered individuals under
15 the plan or other arrangement as of the date of the
16 enactment of the Patients' Bill of Rights Act of
17 2001 and, as of the end of the preceding plan year,
18 the number of such covered individuals does not ex-
19 ceed 25 percent of the total number of present and
20 former employees enrolled under the plan or other
21 arrangement.

22 “(iii) The employee organization or other entity
23 sponsoring the plan or other arrangement certifies
24 to the Secretary each year, in a form and manner
25 which shall be prescribed by the Secretary through

1 negotiated rulemaking that the plan or other ar-
2 rangement meets the requirements of clauses (i) and
3 (ii).

4 “(D) For purposes of subparagraph (A)(i)(II), a plan
5 or arrangement shall be treated as established or main-
6 tained in accordance with this subparagraph only if—

7 “(i) all of the benefits provided under the plan
8 or arrangement consist of health insurance coverage;
9 or

10 “(ii)(I) the plan or arrangement is a multiem-
11 ployer plan; and

12 “(II) the requirements of clause (B) of the pro-
13 viso to clause (5) of section 302(c) of the Labor
14 Management Relations Act, 1947 (29 U.S.C.
15 186(c)) are met with respect to such plan or other
16 arrangement.

17 “(E) For purposes of subparagraph (A)(i)(II), a plan
18 or arrangement shall be treated as established or main-
19 tained in accordance with this subparagraph only if—

20 “(i) the plan or arrangement is in effect as of
21 the date of the enactment of the Patients’ Bill of
22 Rights Act of 2001; or

23 “(ii) the employee organization or other entity
24 sponsoring the plan or arrangement—

1 “(I) has been in existence for at least 3
2 years; or

3 “(II) demonstrates to the satisfaction of
4 the Secretary that the requirements of subpara-
5 graphs (C) and (D) are met with respect to the
6 plan or other arrangement.”.

7 (c) CONFORMING AMENDMENTS TO DEFINITIONS OF
8 PARTICIPANT AND BENEFICIARY.—Section 3(7) of such
9 Act (29 U.S.C. 1002(7)) is amended by adding at the end
10 the following new sentence: “Such term includes an indi-
11 vidual who is a covered individual described in paragraph
12 (40)(C)(ii).”.

13 **SEC. 624. ENFORCEMENT PROVISIONS RELATING TO ASSO-**
14 **CIATION HEALTH PLANS.**

15 (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL
16 MISREPRESENTATIONS.—Section 501 of the Employee
17 Retirement Income Security Act of 1974 (29 U.S.C. 1131)
18 is amended—

19 (1) by inserting “(a)” after “SEC. 501.”; and

20 (2) by adding at the end the following new sub-
21 section:

22 “(b) Any person who willfully falsely represents, to
23 any employee, any employee’s beneficiary, any employer,
24 the Secretary, or any State, a plan or other arrangement
25 established or maintained for the purpose of offering or

1 providing any benefit described in section 3(1) to employ-
2 ees or their beneficiaries as—

3 “(1) being an association health plan which has
4 been certified under part 8;

5 “(2) having been established or maintained
6 under or pursuant to one or more collective bar-
7 gaining agreements which are reached pursuant to
8 collective bargaining described in section 8(d) of the
9 National Labor Relations Act (29 U.S.C. 158(d)) or
10 paragraph Fourth of section 2 of the Railway Labor
11 Act (45 U.S.C. 152, paragraph Fourth) or which are
12 reached pursuant to labor-management negotiations
13 under similar provisions of State public employee re-
14 lations laws; or

15 “(3) being a plan or arrangement with respect
16 to which the requirements of subparagraph (C), (D),
17 or (E) of section 3(40) are met;

18 shall, upon conviction, be imprisoned not more than 5
19 years, be fined under title 18, United States Code, or
20 both.”.

21 (b) CEASE ACTIVITIES ORDERS.—Section 502 of
22 such Act (29 U.S.C. 1132), as amended by sections 141
23 and 143, is further amended by adding at the end the
24 following new subsection:

1 “(p) ASSOCIATION HEALTH PLAN CEASE AND DE-
2 SIST ORDERS.—

3 “(1) IN GENERAL.—Subject to paragraph (2),
4 upon application by the Secretary showing the oper-
5 ation, promotion, or marketing of an association
6 health plan (or similar arrangement providing bene-
7 fits consisting of medical care (as defined in section
8 733(a)(2))) that—

9 “(A) is not certified under part 8, is sub-
10 ject under section 514(b)(6) to the insurance
11 laws of any State in which the plan or arrange-
12 ment offers or provides benefits, and is not li-
13 censed, registered, or otherwise approved under
14 the insurance laws of such State; or

15 “(B) is an association health plan certified
16 under part 8 and is not operating in accordance
17 with the requirements under part 8 for such
18 certification,

19 a district court of the United States shall enter an
20 order requiring that the plan or arrangement cease
21 activities.

22 “(2) EXCEPTION.—Paragraph (1) shall not
23 apply in the case of an association health plan or
24 other arrangement if the plan or arrangement shows
25 that—

1 “(A) all benefits under it referred to in
2 paragraph (1) consist of health insurance cov-
3 erage; and

4 “(B) with respect to each State in which
5 the plan or arrangement offers or provides ben-
6 efits, the plan or arrangement is operating in
7 accordance with applicable State laws that are
8 not superseded under section 514.

9 “(3) ADDITIONAL EQUITABLE RELIEF.—The
10 court may grant such additional equitable relief, in-
11 cluding any relief available under this title, as it
12 deems necessary to protect the interests of the pub-
13 lic and of persons having claims for benefits against
14 the plan.”.

15 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—
16 Section 503 of such Act (29 U.S.C. 1133), as amended
17 by section 301(b), is amended by adding at the end the
18 following new subsection:

19 “(c) ASSOCIATION HEALTH PLANS.—The terms of
20 each association health plan which is or has been certified
21 under part 8 shall require the board of trustees or the
22 named fiduciary (as applicable) to ensure that the require-
23 ments of this section are met in connection with claims
24 filed under the plan.”.

1 **SEC. 625. COOPERATION BETWEEN FEDERAL AND STATE**
2 **AUTHORITIES.**

3 Section 506 of the Employee Retirement Income Se-
4 curity Act of 1974 (29 U.S.C. 1136) is amended by adding
5 at the end the following new subsection:

6 “(c) CONSULTATION WITH STATES WITH RESPECT
7 TO ASSOCIATION HEALTH PLANS.—

8 “(1) AGREEMENTS WITH STATES.—The Sec-
9 retary shall consult with the State recognized under
10 paragraph (2) with respect to an association health
11 plan regarding the exercise of—

12 “(A) the Secretary’s authority under sec-
13 tions 502 and 504 to enforce the requirements
14 for certification under part 8; and

15 “(B) the Secretary’s authority to certify
16 association health plans under part 8 in accord-
17 ance with regulations of the Secretary applica-
18 ble to certification under part 8.

19 “(2) RECOGNITION OF PRIMARY DOMICILE
20 STATE.—In carrying out paragraph (1), the Sec-
21 retary shall ensure that only one State will be recog-
22 nized, with respect to any particular association
23 health plan, as the State to which consultation
24 is required. In carrying out this paragraph, the Sec-
25 retary shall take into account the places of residence

1 of the participants and beneficiaries under the plan
2 and the State in which the trust is maintained.”.

3 **SEC. 626. EFFECTIVE DATE AND TRANSITIONAL AND**
4 **OTHER RULES.**

5 (a) **EFFECTIVE DATE.**—The amendments made by
6 sections 621, 624, and 625 shall take effect one year from
7 the date of enactment. The amendments made by sections
8 622 and 623 shall take effect on the date of the enactment
9 of this Act. The Secretary of Labor shall first issue all
10 regulations necessary to carry out the amendments made
11 by this subtitle within one year from the date of enact-
12 ment. Such regulations shall be issued through negotiated
13 rulemaking.

14 (b) **EXCEPTION.**—Section 801(a)(2) of the Employee
15 Retirement Income Security Act of 1974 (added by section
16 621) does not apply in connection with an association
17 health plan (certified under part 8 of subtitle B of title
18 I of such Act) existing on the date of the enactment of
19 this Act, if no benefits provided thereunder as of the date
20 of the enactment of this Act consist of health insurance
21 coverage (as defined in section 733(b)(1) of such Act).

22 (c) **TREATMENT OF CERTAIN EXISTING HEALTH**
23 **BENEFITS PROGRAMS.**—

24 (1) **IN GENERAL.**—In any case in which, as of
25 the date of the enactment of this Act, an arrange-

1 ment is maintained in a State for the purpose of
2 providing benefits consisting of medical care for the
3 employees and beneficiaries of its participating em-
4 ployers, at least 200 participating employers make
5 contributions to such arrangement, such arrange-
6 ment has been in existence for at least 10 years, and
7 such arrangement is licensed under the laws of one
8 or more States to provide such benefits to its par-
9 ticipating employers, upon the filing with the appli-
10 cable authority (as defined in section 812(a)(5) of
11 the Employee Retirement Income Security Act of
12 1974 (as amended by this subtitle)) by the arrange-
13 ment of an application for certification of the ar-
14 rangement under part 8 of subtitle B of title I of
15 such Act—

16 (A) such arrangement shall be deemed to
17 be a group health plan for purposes of title I
18 of such Act;

19 (B) the requirements of sections 801(a)(1)
20 and 803(a)(1) of the Employee Retirement In-
21 come Security Act of 1974 shall be deemed met
22 with respect to such arrangement;

23 (C) the requirements of section 803(b) of
24 such Act shall be deemed met, if the arrange-

1 ment is operated by a board of directors
2 which—

3 (i) is elected by the participating em-
4 ployers, with each employer having one
5 vote; and

6 (ii) has complete fiscal control over
7 the arrangement and which is responsible
8 for all operations of the arrangement;

9 (D) the requirements of section 804(a) of
10 such Act shall be deemed met with respect to
11 such arrangement; and

12 (E) the arrangement may be certified by
13 any applicable authority with respect to its op-
14 erations in any State only if it operates in such
15 State on the date of certification.

16 The provisions of this subsection shall cease to apply
17 with respect to any such arrangement at such time
18 after the date of the enactment of this Act as the
19 applicable requirements of this subsection are not
20 met with respect to such arrangement.

21 (2) DEFINITIONS.—For purposes of this sub-
22 section, the terms “group health plan”, “medical
23 care”, and “participating employer” shall have the
24 meanings provided in section 812 of the Employee
25 Retirement Income Security Act of 1974, except

1 that the reference in paragraph (7) of such section
2 to an “association health plan” shall be deemed a
3 reference to an arrangement referred to in this sub-
4 section.

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