



United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 105th CONGRESS, SECOND SESSION

Vol. 144

WASHINGTON, FRIDAY, JULY 24, 1998

No. 101

House of Representatives

The House met at 9 a.m.

The Chaplain, Reverend James David Ford, D.D., offered the following prayer:

When all is said and done, O God, we are aware and appreciative of all Your gifts to us and to all people. We have been blessed in ways that have been greater than our deserving. Your grace has touched our lives with love and compassion and mercy. O gracious God, from whom all blessings flow, we ask Your benediction on us and those about us that in all things Your hand will sustain us and Your mercy will be without end. This is our earnest prayer. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from New York (Mr. SOLOMON) come forward and lead the House in the Pledge of Allegiance.

Mr. SOLOMON led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate had passed without amendment a bill and a concurrent resolution of the House of the following titles:

H.R. 39. An act to reauthorize the African Elephant Conservation Act.

H. Con. Res. 298. concurrent resolution expressing deepest condolences to the State

and people of Florida for the losses suffered as a result of the wild land fires occurring in June and July 1998, expressing support to the State and people of Florida as they overcome the effects of the fires, and commending the heroic efforts of firefighters from across the Nation in battling the fires.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain one-minutes after legislative business.

PATIENT PROTECTION ACT OF 1998

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 509 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 509

Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 4250) to provide new patient protections under group health plans. The bill shall be considered as read for amendment. The amendments printed in the report of the Committee on Rules accompanying this resolution shall be considered as adopted. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except: (1) one hour of debate on the bill, as amended, equally divided and controlled by Representative Hastert of Illinois and a Member opposed to the bill; (2) the further amendment printed in the Congressional Record and numbered 2 pursuant to clause 6 of rule XXIII, which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read, and shall be separately debatable for one hour equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, I am going to depart from normal custom and

yield the first minute of this to the distinguished gentleman from New York (Mr. LAZIO) for a matter of colleague comity.

(Mr. LAZIO of New York asked and was given permission to speak out of order.)

HONORING THE HONORABLE ROB PORTMAN

Mr. LAZIO of New York. I want to thank the gentleman from Florida (Mr. GOSS) and the gentleman from New York (Mr. SOLOMON) for their courtesy.

Mr. Speaker, I rise to honor my pal and colleague, the gentleman from Ohio, Mr. ROB PORTMAN. He is one of the most accomplished people in this Congress. He stood up for America's taxpayers and was the driving force behind the landmark IRS reform bill signed into law this week. He authored the National Underground Railroad Act signed into law this week. By preserving underground railroad sites, America celebrates the journey of slaves from bondage to freedom.

The gentleman from Ohio is the congressional leader in the war against drugs. His Drug-Free Communities Act, signed into law, will give us peace of mind when our children are away from home. His pro-business mandates legislation is the law of this House and his pro-environment tropical rain forest legislation should be signed into law next week.

In an era when bipartisanship is essential for legislative success, Rob Portman is the even-headed leader we need. He is balanced and principled, substantive, competent, intelligent. He is a man of integrity, of modesty and of great character.

The gentleman from Ohio, Mr. ROB PORTMAN, gets the job done for families in Cincinnati, in Ohio, and throughout America.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would like to announce that the rules do not allow Members to wear badges when they are addressing the

□ This symbol represents the time of day during the House proceedings, e.g., □ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.



Printed on recycled paper.

H6297

House. The Chair will enforce this rule throughout the debate today.

Mr. GOSS. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this is a structured rule that allows timely consideration of this very, very important legislation on health care. In yesterday's Rules meeting, which actually went on for quite a while, the minority requested that the Dingell substitute be made in order and we indeed have obliged them in this rule. It provides for 1 hour of debate on the Patient Protection Act to be equally divided between the gentleman from Illinois (Mr. HASTERT) and an opponent, and 1 hour of debate on the Dingell substitute. These are two very different approaches to providing better health care for more Americans and I am sure that we will have quite a vigorous debate on the merits of each today. Finally, the rule provides for one motion to recommend with or without instructions. In effect, giving the minority two bites at the apple. I certainly feel this is a fair rule.

Mr. Speaker, today we will move to restore true patient power. The Patient Protection Act is the only bill that restores commonsense patient protections to Americans while also extending affordable coverage to the 41 million Americans who currently lack it and cannot get health care coverage. One clear difference between the two approaches is the fact that the Kennedy-Dingell Patients' Bill of Rights makes no effort to secure affordable health insurance for the 40-plus million Americans who have none currently. In fact, when asked what the Kennedy-Dingell bill does for uninsured Americans, the minority leader in the other body reportedly summed it up in two words, and I quote, "Not much." Instead of turning our backs on the uninsured, our bill attacks their problem head-on. We know that over 75 percent of uninsured Americans are in a family where the primary caregiver works for a small business. This is especially true in southwest Florida, which I represent, where mom and pop shops cannot afford to provide their employees with health insurance. The Patient Protection Act allows small businesses to pool their resources and the achieve economies of scale needed to offer quality, affordable health insurance to their employees. If it is good enough for the Microsofts and the IBMs and the GMs of the world, should it not be good enough for the little guys, too? We take care of that.

As with any major proposal, there comes a certain level of misinformation and this effort is no exception. Many of my friends on the other side of the aisle have confused a patient's bill of rights with a trial lawyer's right to bill. Under our bill, patients would still

have the right to sue their HMO for malpractice and that includes punitive damages. I wonder how many times I am going to be saying that in the next few months. Under our bill, patients would still have the right to sue their HMO for malpractice, and that includes punitive damages. I think we are going to be hearing some debate on that subject today. If the HMO runs the wrong tests on you or they happen to cut off the wrong foot, you will have recourse through the courts, of course. That is essential and that is protected. But as we studied the problem and talked to people, the folks who were being denied care in what we call coverage disputes, we thought we could do better than settling for, or encouraging even more litigation. I do not know many people who have gotten much good medical attention in a courtroom. We came to the conclusion that we have an innovative solution that assures patients get the care they need, up front, when they need it, at a place they need it, from a doctor, from a real medical person. Our expedited internal and external appeals process means that if your HMO denies your experimental treatment, or your treatment, you will be able to have a doctor, independent of the HMO, review that decision. Of course if you are unsatisfied at the end of that process, you can take the offending HMO to court. However, unlike the current law, the judge will have the flexibility to serve a fine up to \$250,000 against the HMO plan. This is not available under current law and it is a healthy and reasonable constraint on HMO abuse. I know it has already got their attention.

We have provided commonsense patient protections in this package. Women will have direct access to their OB-GYN. Kids will get to see a pediatrician without any red tape or having to get permission from a government official. And, most importantly, doctors will have no restrictions on the recommendations they give their patients. No gag rule. These are positive steps to improve the doctor-patient relationship, not a retreat into more nonsensical and, I would say, very expensive bureaucracy that other approaches take.

Mr. Speaker, as a member of Chairman HASTERT's working group, I can assure you that we have worked hard and I think we have come up with a pretty good package that provides real protections without returning us to the days of double-digit inflation. I encourage my friends on both sides of the aisle to ignore the demagogues and focus on the pro-patient, pro-small business, pro-family provisions in our health care bill. I believe they will find it is worth reading.

Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, there is no doubt that the American public wants managed care reform. Today we have the oppor-

tunity to respond. At long last after months and months of denying that a problem exists, the Republican majority has agreed to let the House vote on a bill that seeks to provide a response to the concerns of millions of Americans. While what we have before us today is two bills, one written behind closed doors by the Republican leadership and supported by the insurance industry, there really is only one bill which meets the critical test of addressing the concerns of our constituents. That bill is a bipartisan proposal supported by doctors, nurses and consumers.

Mr. Speaker, there are two bills before us today, but if we listen carefully to what our constituents have been saying, there is little doubt how we should vote. Only the bipartisan bill sponsored by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) really offers working families what they have been asking for. The bipartisan Ganske-Dingell Patients' Bill of Rights assures working families access to necessary medical care and will return health care decision-making to patients and their doctors. The bipartisan bill will give patients real remedies for real problems. The Ganske-Dingell Patients' Bill of Rights will reform a system that is badly in need of repair.

My Republican colleagues will say today that the bipartisan bill is nothing more than big government. They will say the bipartisan bill is nothing more than a lawyers full employment act. Well, if that is the case, Mr. Speaker, why then is the Ganske-Dingell substitute supported by the American Medical Association, an organization not normally known to support big government or trial lawyers? Why then is it supported by the American Nurses Association, an organization representing those health care givers closest to the patient? Why then, Mr. Speaker, is it supported by consumer groups and opposed by insurance companies? The arguments my Republican colleagues will make against the Ganske-Dingell bill are just plain bogus and no one should be fooled. Ganske-Dingell offers real reform, not just election year posturing.

That we are even able to consider and debate Ganske-Dingell today is testimony to the power of the call of the American people. For far too long, my Republican colleagues have denied that there is a problem, but the voices of working families who have been demanding that the Congress respond to their real concerns has been heard.

□ 0915

In their efforts to deny the House the opportunity to respond to those concerns, the Republican leadership had us guessing until 12:30 a.m. this morning whether they were even going to give the bipartisan substitute a place at the table. I suspect that only after it became clear that the rule might not pass without the Ganske-Dingell

amendment made in order that the Republican leadership relented and agreed to make the substitute in order.

Mr. Speaker, every Member in this House needs to recognize that the bipartisan substitute offers American working families something more than election year rhetoric. Ganske-Dingell is a good bill and deserves the support of every Member of this body. To do less is to do disservice to our constituents. I urge Members to do the right thing and to support Ganske-Dingell.

Mr. Speaker, I reserve the balance of my time.

Mr. GOSS. Mr. Speaker, I yield as much time as he may consume to the distinguished gentleman from Glens Falls, New York (Mr. SOLOMON), chairman of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, I was not going to speak this morning. We spoke enough yesterday and last night into the wee hours. But I just want to make sure that all the Members on both sides of the aisle know, as the gentleman from Florida (Mr. GOSS) has just outlined, that this is a negotiated fair rule that was approved by the Democrat minority.

The Dingell substitute is made in order with ample time for debate so that this House has its choice, and that is the way that it should be. I just want to point out that we are going to be somewhat repetitive here, because what is going to be said now in this next hour on the rule could have not been wasted if we had had unanimous consent.

The gentleman from Michigan (Mr. DINGELL) last night agreed to unanimous consent to bring this bill on the floor without taking this extra hour of time on the rule. That means that Members could have gone back home. It is difficult in these last 3 or 4 weeks now before we recess for the August break, and taking up the rule today is going to add another hour and a half. It is too bad that the Democratic minority objected to us offering a unanimous consent to bring this bill on the floor, and I just wanted Members to know that.

But I hope that they will come over and vote for the rule, vote for the bill, and we will at least will have made some great progress in patients' rights.

Mr. FROST. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the gentleman from New York was bemoaning the fact that we could not bring this measure up under unanimous consent but, rather, that we would have an hour's debate on the rule. This may be the most important piece of legislation we will consider this year. Certainly it is reasonable to have an hour debate on the rule on this matter.

The other side was so anxious to bring this up quickly early this morning and out of the line of fire without public attention. It is clearly appropriate to have an hour's debate on the rule.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

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

Mr. GREEN. Mr. Speaker, I thank my colleague and friend, the gentleman from Texas, and a Member of the Committee on Rules for allowing me to speak this morning.

I rise, not in opposition to the rule, but in opposition to the process where we have gotten to today, Mr. Speaker. Managed care reform is not about politics; it is about people.

We have a responsibility to guarantee the American people top quality health care. We have a responsibility to protect our children from negligent medical decisions made by insurance companies.

The Republican proposal that we will be debating today is simply profit over people. The only people in our country who are guaranteed immunity from their decisions are foreign diplomats and HMO officials.

We cannot really have a Patients' Bill of Rights without access to specialists, a timely internal and external appeals process, point of service options, choice for our patients, accountability of that decision matter, and open communication between the patient and a provider; in other words, no gag rule.

Can we honestly say that the system will protect patients without an enforcement mechanism, without an accountability? There is no responsibility.

The Republican bill that will be voted on today never enjoyed a public hearing. It was drafted behind closed doors. In fact, I serve on the committee that would have been helping draft this bill, and we did have hearings over the last few months, but this bill never had a public hearing.

We did not see it until late last night. Do my colleagues know why? Because, one, it does not end gag rules. It does not define severe pain as a reason a constituent of mine can go to the emergency room. It also does not actually provide for the point of service option that we want, the choice for that patient. That is easily bypassed by the HMO decision makers.

The Republican bill also will decide what medically necessary is. My concern is we are not giving the patient and that physician or that provider the decision making that the Democratic bill provides; and that is why, later on today, we hopefully will pass the Dingell-Ganske bill.

Mr. Speaker, I include the following for the RECORD:

ISSUES OF CONCERN IN THE HASTERT TASK FORCE BILL

Does not end gag rules

While the bill claims to end gag rules, the statutory language creates a loophole that guts the protection. Under the Balanced Budget Act, Medicare and Medicaid plans cannot "prohibit or otherwise restrict" medical communications. The GOP bill only refers to prohibitions. So a plan could "allow" medical communications, but only after the doctor first complies with certain restric-

tions (such as calling the plan first and delivering the advice in pig latin). The deletion of the words "or restrict" render this protection hollow. This also creates the possibility for lawsuits over whether something is a restriction or a prohibition.

Does not define/include "severe pain" as a reason to get "emergency medical care"

The access to emergency care language in Medicare and Medicaid contains a specific definition of what a prudent layperson would think required immediate treatment: "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part."

By contrast, the GOP bill does not include "severe pain" as a condition that health plans must cover in the emergency room. The deletion is significant. For example, the American Heart Association advises that anyone experiencing crushing chest pain should go to the ER immediately, as that is a warning sign of a possible heart attack.

Under H.R. 4250, a health plan can refuse to pay the ER bills of a man who went to the emergency room with crushing chest pain but whose EKG came out negative. That might be only a temporary result; he might have a heart attack when the plan gives him a bill for the ER services!

Allows the plan to decide what is "medically necessary"

At its heart, the debate over HMO reform is really about ensuring that health care decisions are made by doctors and patients, not by HMO business executives. H.R. 4250, however, does not fulfill that promise. Under the disclosure section, plans must inform participants of whether care may be excluded because "of a failure to meet the plan's requirements for medical appropriateness. . . ." In other words, it is not the doctor and patient who decide what is medically necessary; it is the plan which retains that capability.

During Commerce Committee testimony two years ago, Dr. Linda Penno, a former HMO medical reviewer, described this as a plan's 'smart-bomb' capability. By retaining the power to define what is and what is not medically necessary, the plan is able to take control of health care decisionmaking.

This is also relevant to the external appeals provisions of the Hastert Task Force Bill. The review is limited to whether the plan followed its own definition of medical necessity or whether or not a treatment is experimental.

Point of service provision is easily by-passed

The most powerful argument in the health care debate is the right to choose your own doctor. The GOP bill attempts to respond to this by including a point of service provision for closed panel HMOs (allowing patients to see providers outside the network). H.R. 4250, however, contains loopholes that effectively gut the provision. Employers would not have to offer employees point of service coverage if they could prove that this will cause premiums to rise just 1%—even if all of the added costs would be borne by employees who chose this option! And this "proof" could be prospective—meaning a company would not have to offer a single employee a POS option to determine its actual effect on premiums.

I am concerned that it will be easy for employers to "prove" that premiums will increase 1%. For example, one study by opponents of this legislation suggested that managed care reform legislation would increase premiums between 3 and 90%. While CBO's very low estimate of 4% should put those wild allegations to bed, they show how easy it is to prospectively make a doom and gloom forecast with a straight face. Combine that with the fact that insurance premiums are expected to take a big jump this year, and it is not hard to see how health plans will be able to use the 1% threshold to avoid offering their employees a choice of health care providers.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Speaker, I want to thank the Committee on Rules for bringing a fair rule to the floor. I intend to support it. I encourage all my colleagues to support the rule.

Mr. Speaker, think about how far we have come in the last 6 months. Six months ago, we would have never had this debate on the abuses in managed care. Today we are going to have that debate.

Let me briefly outline some of the arguments you will hear today so you can evaluate the competing proposals. Here is a sample of key protections which are not included in the Hastert task force bill, but are included in the substitute plan that I will offer:

The Ganske-Dingell substitute provides patients with access to clinical trials. The Hastert bill does not.

The Ganske-Dingell substitute allows doctors to override drug formularies when medically necessary. The Hastert bill does not.

The Ganske substitute provides for ongoing access to specialists for chronic conditions. The Hastert bill does not.

The Ganske substitute prevents plans from giving doctors financial incentives to deny care. The Hastert bill does not.

The Ganske substitute has hospital stay protection for mastectomy patients. The Hastert bill does not.

The Ganske substitute provides choice for doctors within the plan. The Hastert bill does not.

The Ganske substitute has a provision for guaranteeing continuity of care when providers leave the network. The Hastert bill does not.

The Ganske substitute requires plans to collect quality data or to maintain quality improvement programs. The Hastert plan does not.

There are other significant provisions in the Hastert bill that are of significant concern. The Hastert bill allows a plan to decide what is medically necessary. The Hastert bill requires enrollees to spend their own money to secure an independent review.

Finally, I would draw your attention to the HealthMart and MEWA, Multiply Employee Working Association, provisions which could make it more difficult for States to fund high-risk pools and other programs to help keep health insurance affordable. I am glad

to support the rule. I look forward to the debate today.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding to me. I am going to oppose this bill today and I am going to oppose the rule here today, because we are going to have 2 hours, basically, to debate this bill.

I think it shows the insensitivity of this rule, insensitivity to basic rights that every American demands, and insensitivity to a basic understanding to health care in this Nation.

We as parents, we all know the world stops when a child falls ill. As sons and daughters, we want the best for our parents when they need health care. As husbands and wives and brothers and sisters, when a family member is stricken, we insist that nothing comes between that patient and their health care. We want the best possible treatment. Unfortunately, the Hastert bill does not provide it.

That is what health insurance is supposed to be about. We pay for it, we have it, and we want it when we need it. The doctors, the nurses, the hospitals, the emergency room, the medicine, we want whatever it takes to get our child, our parents back healthy again. That is how it used to be.

But in the last years, millions of Americans have moved into managed care plans, and something got in the way. Priorities were shifted from patients to profits. Emergency room crises were compromised by boardroom considerations. Professionals in white lab coats start taking orders, not from doctors, but insurance bureaucrats. The delivery of top-notch health care became less important; and the bottom line, profit.

When we take a look at the bill today, we will see that the Democratic bill, the Ganske-Dingell bill is the only one that will get the job done for us when we pay for health care and we demand quality care.

The Democratic bill is designed to provide medical coverage. Medical professions will be back in control of medical decisions. Emergency care in an emergency, no questions asked, underneath the Democratic plan. Expedited appeals process to approve the care we deserve before it is too late. Access to a specialist when you need it.

I hope we will defeat this rule and put some time into the Democratic plan.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would note to the gentleman who just spoke that we have tried very hard to accommodate all the schedules. It is a busy time of year. But surely our plan is more sensitive for the debate of this important issue than the discharge petition that they have provided for.

Mr. Speaker, I am very pleased to yield such time as he may consume to the distinguished gentleman from Illi-

nois (Mr. HASTERT), the leader of the Speaker's task force on health care.

Mr. HASTERT. Mr. Speaker, today is an important day for American families. Today we will take a step forward to strengthen the Nation's health care system. Today we will debate and vote upon the House Republican-sponsored Patient Protection Act.

Our legislation is the only proposal on the table that truly protects patients and guarantees choices without the heavy hand of big government. Specifically, our bill guarantees patients have increased access to affordable health care they need when they need it most by holding insurance companies accountable.

How? Our proposal guarantees the unprecedented expedited review process internally and externally. We want patients to receive the care they need first rather than be thrown into a long, drawn-out legal process controlled by lawyers after harm or death has occurred. Patients should be treated in hospital rooms, not courtrooms.

Besides true accountability, our plan has another major advantage over other proposals in this Congress. The Patient Protection Act is the only bill which will help cover the 42 million uninsured working Americans.

We create new initiatives to guarantee more access to affordable health care choices. Association Health Care Plans, HealthMarts, Community Health Organizations, and Expanded Medical Savings Account help employees and employers work together to provide the coverage that best meet their need.

As a matter of fact, just this week at a news conference, the Senate minority leader TOM DASCHLE was asked, "What does the Democrat plan do for the uninsured?" His response, "Not much." At least he was truthful.

I hope my colleagues on the other side of the aisle today are just as forthright and resist the temptation to distort the facts about what is in the House Republican plan. We truly believe that high quality health care depends upon the patient-doctor relationship.

Personally, I believe that doctors owe their patients the benefit of their education, the benefit of their experience, and the benefit of their good judgment. Medical decisions should be decided by doctors, not by insurance company bureaucrats.

We prevent health plans from gagging doctors for explaining the full range of treatment options available no matter what the cost, no matter if the other options are covered by the plan or not. We also ensure patients have ready access to emergency room care and prohibit their health plan from arbitrarily refusing to pay for it. We guarantee that women and children have direct access to their doctors without having first going to the insurance company gatekeeper.

Our proposal will also empower patients and doctors through information. It creates new access to plan coverage information while also protecting individual patient records from abuse through new confidentiality requirements.

□ 0930

Access to affordable health care is a fundamental patient protection. Without affordability, you cannot have accessibility, nor, for that matter, health care coverage at all. As you can see, we are protecting patients and guaranteeing choices, without the heavy hand of big government.

Mr. Speaker, we must have a comprehensive approach to meeting America's health care needs. Our Patient Protection Act is the only proposal before Congress that increases accessibility, affordability and accountability in our health care system. I urge my colleagues to support this rule so we can deliver the health care reform that Americans need.

Mr. FROST. Mr. Speaker, I yield three minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I do want to first thank the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE) and the members of the Democratic Health Care Task Force and all those who worked very hard to make sure that this substitute came up today. The discharge petition effort, which I think has over 190 Members, and other efforts to appear before the Committee on Rules finally brought fruit, I think, and made it possible for us to bring the substitute up today, and that hard work, I believe, paid off.

In my view, there is nothing more important in the managed care debate than giving patients the right to hold their HMO accountable when they are denied the care they need. Any legislation that fails to give patients that renders the protections within it absolutely meaningless. The Patient's Bill of Rights includes an enforcement mechanism which ensures patients will finally get that right. Our bill repeals the ERISA exemption, the 1974 law which shields HMOs from being sued if they deny people needed care.

The other bill we are considering today, the Republican bill, does nothing to hold HMOs accountable for their actions. If not only leaves ERISA essentially intact, it actually exacerbates the problem. Its external appeals process only applies to people whose insurance comes under ERISA. Individuals in the private insurance market are left without any external recourse when they are denied care. What is even worse is that those who are fortunate enough to be covered by ERISA are subject to the HMO's definition of "medical necessity."

The Republican bill allows HMOs, and not doctors and patients, to define "medical necessity." This provision, of course, flies in the face of the whole

idea of managed care debate, that medical necessity should be the determinant of whether or not a patient needs care and not cost considerations. It all but guarantees that insurance company bureaucrats will continue to make medical decisions and people will continue to be denied care because of it.

I also want to dispel a myth that my Republican colleagues have been working overtime to spread. The Patients' Bill of Rights does not create any new Federal legislation. Repealing the ERISA exemption would simply allow patients to go back to their states, where individuals would normally bring suit. In other words, the Patients' Bill of Rights does not create a new Federal remedy. Its approach is essentially states' rights by repealing a Federal preemption.

Another piece of propaganda the Republicans have been actively spreading is the charge that the Patients' Bill of Rights provides for employers to be sued for medical malpractice. This is patently false. In fact, the Patients' Bill of Rights specifically excludes employers from liability. Any employer can only be held liable if they intervene in a medical decision that leads to injury or death.

Mr. Speaker, President Clinton recently said that "a right without a remedy is not a right," referring to HMOs. If you want good patient protections, and, just as importantly, enforcement of those protections, vote "yes" on the Patients' Bill of Rights and vote "no" on the Republican bill.

Mr. GOSS. Mr. Speaker, I yield two minutes to the distinguished gentleman from Kentucky (Mr. BUNNING).

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

Mr. BUNNING. Mr. Speaker, I rise in strong support of the rule and the Patient Protection Act. This bill is a well-crafted piece of legislation which addresses many of the problems facing our Nation's rapidly changing health care system.

What the bill does makes it worth supporting. It strengthens health care plan accountability by providing a system of reviews and appeals, to make sure that Americans who have health insurance get the care they need when they need it; it guarantees patients' choice by ensuring a point of service option, so that patients have the freedom to see the provider of their choice; it expands the availability and affordability of health insurance for millions of Americans through the creation of HealthMarts and Association Health Plans, by creating Community Health Center networks, and by expanding Medical Savings Accounts; it guarantees the right of patients to emergency room service; it guarantees the right of women to have direct access to their OB-GYN; it guarantees parents the right to direct access to pediatricians for their children.

These are much-needed improvements, and they are the one big reason

to support the Patient Protection Act, the things it does.

But there is another reason to support the Patient Protection Act, and that is what it does not do. It does not load down the health care system with a new layer of bureaucracy; it does not guarantee an explosion of unnecessary costs and costly litigation, it puts people into care, and not into courtrooms; and it would not increase the cost of health care dramatically, like the Patients' Bill of Rights would do.

Mr. Speaker, it is a very good piece of legislation because of what it does, and even because of what it does not do.

I urge my colleagues to support the Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield two minutes to the gentlewoman from the Virgin Islands (Ms. CHRISTIAN-GREEN).

Ms. CHRISTIAN-GREEN. Mr. Speaker, I thank my colleague for yielding me time.

Mr. Speaker, I rise in support of the Ganske-Dingell bill. As a physician who has practiced medicine for more than 20 years, I know well many of the troubling aspects of the industry, particularly as they affect minorities. That is why I rise today to support the Ganske-Dingell bill and to bring to this body's attention and to the attention of the American people an issue which might not be discussed today, the discrimination of African-American physicians and patients by managed care plans.

Because minority physicians often serve poorer, sicker and are often solo practitioners and not a part of a group that makes a tidy profit each year, we do not make attractive candidates for inclusion into managed care plans.

Similarly, because minority patients are often uninsured and receive medical assistance from programs such as Medicare and Medicaid, they are also not attractive sources of revenue to such plans as well. As we seek to reform the managed care industry, we must not forget the concerns of minorities in this effort and their struggle to have their health care needs addressed.

My friends in the majority must stop playing politics with the lives of the American public and pass the Patients' Bill of Rights. The people who put us here and depend on us have asked us for and deserve a better health care delivery system. The Ganske-Dingell bill does that. I urge its passage. Let us put the "care" back in health care.

Mr. FROST. Mr. Speaker, I yield three minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, before coming to this Congress, I worked each day in a much different place, in a courtroom, as a judge on the highest court in Texas. I was called a justice, as were my colleagues, and asked to do justice. And yet, time after time, I found my hands and those of my colleagues tied by a Federal law.

We saw victims of injustice, who had suffered not only some grievous loss in

terms of an illness or an injury, but the same families who suffered abuse at the hands of insurance companies, and, because of a law that was passed in this National capital, we were powerless to do anything about it.

Recently the State of Texas became the first state to pass a new law to try to hold these managed care companies accountable for what they were doing. And, wouldn't you know it, the same insurance companies that used to come into my court went into another court to try to block this new state accountability law.

Today that same group of health care companies finds willing allies over here from the Republican leadership to help them continue to do the very same thing. They are folks who would deny help to the infirm. What is happening here is much like a firefighter, who sometimes builds a small fire in order to stop a much larger fire. There is a fire of outrage burning across this country, as one family after another suffers abuse and limitation of care at the hands of managed care companies.

So the Republican leadership has come forward today in a very contrived fashion. They tried to provide the least amount of reform possible and still call it "patients rights," while doing essentially nothing to untie the hands of judges all across this country to provide a remedy.

Mr. Speaker, they say that what they are about is providing help to patients and not getting lawyers in the process. But, you know, that is false under their whole procedure. They keep lawyers involved in the process. They keep them involved only for the insurance company, not for the victim of the insurance company's abuse. They say that it is okay to have the lawyers that write the loopholes, that counsel the insurance companies to interfere with some clerk, who never had any health care experience, in the best recommendations of a physician or other health care provider to help that physician's patient get well. But Republicans would deny any enforcement, any accountability, for that insurance company.

They say they are opposed to getting juries involved in this process, and that is also false. They simply leave the only jury as not a jury of one's peers, but an insurance company, that acts as judge, jury and, in too many cases, executioner when it comes to providing health care. We would remedy that through the Dingell proposal, not through some election year sop.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise in support of the Ganske-Dingell bill and truly relish this debate. I truly wish we had more time for it.

Today we are going to vote on a Republican sham HMO reform bill which actually leaves patients with less rights than they have under current law.

Let me give you an example. The GOP bill will repeal state laws that keep HMOs from giving out your private medical records. Under this Republican proposal, your employer could call for your medical records and your HMO could release your personal medical records without your permission.

But the worst thing about this political charade is that the Republican bill does not address the one problem that millions of Americans have asked us to fix, that doctors and patients should make medical decisions, not insurance company bean counters.

Under the GOP bill, HMOs will continue to define what is medical necessity and accountants will continue to decide what medical care Americans ought to receive. And if some HMO bureaucrat with no medical training makes a mistake that injures or kills you or a member of your family, you have no legal recourse. The GOP bill says, too bad, and tough luck.

This is a sham bill, and that is why the American Medical Association and dozens of other medical groups oppose it, and why the HMO companies support it. It has no protections and no enforcement mechanism. That is why the President has said he will veto it.

Let us pass real reform for the American people in this country. That is what they want, that is what they need. Pass the Democratic Patients' Bill of Rights. It is the way that we need to address the serious issue of getting back the decisionmaking between doctors and patients, and out of the hands of the HMOs.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, regrettably, the last speaker has been victimized by misinformation in the paper, in the Washington Post this morning, as have other Members. When we get to the debate we will explain that much of what was presented was incorrect.

Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Missouri (Mr. TALENT), a member of the special task force.

□ 0945

Mr. TALENT. Mr. Speaker, I thank the gentleman for yielding me this time.

I am very pleased to rise in strong support of the Patient Protection Act because it is the only bill on the House floor today that will provide health care coverage to millions of people, hard-working Americans who currently do not have it. It is the only bill that will ensure that Americans who have health care coverage get the coverage their physician recommends when they need it, before they get sick, and it is the only bill that does what it does without big government and big bureaucracy.

First, access to the uninsured. Mr. Speaker, there are 42 million Americans today who do not have health care coverage. Most of them work for small employers who, because of the high ad-

ministrative costs and the low buying power with small pools, cannot afford to provide them health insurance. If they worked for IBM, they would have access to a variety of different options.

So what our bill does is allows those small employers to pool together and get the buying power of a pool. It will cover millions of people with good, private sector health insurance and provide many more choices to millions of those who currently only have one choice or two.

What does the Dingell bill do? What does it do for the uninsured? Well, according to a cosponsor from the other body, not much. In fact, the "not-much" plan is worse than not much, because according to the CBO, it will drive costs up to the point that 1.6 million people who now have health insurance will be thrown off the health insurance rolls.

Our bill also ensures that people will get the care they need when they need it, and does it without big government. It provides swift, certain, low-cost access for somebody whose physician has recommended care whose plan has turned it down to get that decision reversed. First internal review has to be before a physician, not a health care professional, not a nurse. That is a difference from the Dingell bill.

Second, automatic appeal has a right to an external review before physicians. The Dingell bill does not have that. We get people in the treatment rooms, not waste billions of dollars that should be spent on health care in the courtrooms.

Mr. Speaker, all of us who have dealt with this issue have dealt with the stories about people who have needed coverage and have had it denied by their managed care plans. Those are not just horror stories, they are horrible stories. Tales of human misery, of pain, of loss of babies, loss of limbs; that should not happen. Under our bill and only under our bill those stories would not have happened and will not happen in the future.

That is what this debate today is about, that is what this bill is about. It should not be about politics, it should not be about an issue for November; it should be about helping the people to get the care that they need when their physician recommends it. That is why I rise in strong support of the Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas, (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, it is ironic that I stand here and know so well that every taxpaying American has paid for much of the research that persons now are denied the result of.

I wish this was not such a partisan area, because we are dealing with the most basic need and right of the American people, and that is health care. No insurance company has the right to only insure young, healthy people.

I have heard all kinds of rhetoric about the bureaucracy. The bureaucracy rests with the insurance companies who are doing everything they can to deny care so that health care premiums can be used as cash cows. That is most unfortunate. Can we imagine someone who goes to an emergency room, very ill, very confused and frightened, and then be told they have to wait to get permission to take care of them. That is where we are today.

I do not understand, frankly, how we can become so committed to an industry, the insurance industry, that we forget that we are here to protect people.

Mr. Speaker, I rise against this rule because I do not want it to continue to gag physicians who have been educated and trained to take care of patients. I do not want to support a system that only makes money for the insurance companies. It has been never intended that health care services be cash cows for insurance companies.

This is a terrible rule. I hope we all understand that the people are crying out for help. They do not mean help the insurance companies. They want help themselves.

We owe it to the American people to offer them this protection. We have failed to do it with this Republican plan, and I rise against this rule and ask everyone to vote against it until we can produce a decent plan.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume to say to the gentlewoman that I hope she will be relieved to find when she reads our bill that we have, in fact, removed the gag order.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. PAUL).

Mr. PAUL. Mr. Speaker, I thank the gentleman for yielding me this time.

I rise in support of the rule. Under the circumstances, the rule is very fair. It offers an opportunity for our side to vote for the Patient Protection Act as well as a vote for the opposition. I think that is quite fair, so I strongly support the rule.

I would like to call to the attention of my colleagues one particular part of our bill that I think is very important and addresses a problem I see as being very serious.

In 1996, the Kennedy-Kassebaum bill allowed for a national identifier and a national data bank to control all our medical records at a national level. This is very dangerous. In a bill that is called the Patient Protection Act, obviously the best thing we can do is protect patient privacy. If we do not, we interfere with the doctor-patient relationship, and this is a disaster.

This whole concept of a national identifier—the administration is already working to establish this—is dangerous and we must do whatever is possible to stop it.

I compliment the authors of this bill to prohibit this national medical data bank.

Mr. FROST. Mr. Speaker, I would inquire about the time remaining.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Texas has 11 minutes remaining and the gentleman from Florida has 10 minutes remaining.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. TRAFICANT).

Mr. TRAFICANT. Mr. Speaker, I support the rule; I also support the Democrat substitute, and if it fails, I will support the Republican bill. Both bills are better than the current system, and the need for reform is greater than Democrat and Republican posturing.

Doctors should make decisions on our health care, not businessmen. Patients should be able to choose the doctor they want. Insurance companies and business managers without medical degrees should not be delivering our health care system.

Mr. Speaker, I say to my colleagues, this current system is not managed care; this system in America is managed cost. Dollars are all they see, not pain, not disease, not people, not children, not cancer, not cures; they see dollars.

The Congress of the United States is appropriately making necessary changes today, and these business people have to understand that the American people want a doctor, not an accountant, when they have a gall bladder problem, I say to my colleagues. And hospitals should not be throwing them out because of dollar concerns; it should be predicated on sound medical practice.

It is a shame when Congress has to intervene, but America has gone from the Hippocratic oath to hypocrisy in a managed cost health care system.

I will support whatever survives; it is better than the animal that still lives.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Speaker, I am glad to be a part of this debate. In my previous life I was part of the Kentucky General Assembly, and while they were altruistic legislators that created the disaster that we had in Kentucky, the fact is that that is exactly what they created, a terrible disaster.

We had what would be proposed today by the Democrats in the term of health care reform, and what it created were enormously escalating prices, prices that escalated so fast that we tried to intervene by capping the prices of our insurance premiums. What did that do? It chased 45 out of 47 of the insurance companies that were selling insurance in Kentucky right out of the State.

So what did our consumers in Kentucky get left with? They got left with higher prices for insurance, they got left with higher copayments, and they got left with fewer choices.

I am so proud to be here today, to be part of an effort to give the American

people what they really want. What do they want? They want essential medical services. They want them to be affordable, both the insurance and the copayments, and they want more choices. We are taking a giant step in that direction today.

What we are doing is helping make sure that medical money stays in medicine. The American people resent the fact that they pay for their insurance, that their employer contributes to their insurance, and they make copayments, and a tremendous amount of that money gets diverted to lawyers, to court costs, to liability costs and to administrative costs.

We need to make sure that all the money we spend in medicine, understanding that there is a finite amount of money that gets spent on good health delivery, for patients when they need it.

We need to make sure that we do not create a bill that has so many mandates in it that we begin to say to the American people, you are going to pay more and more because we know what you need and want, not you. I thank the task force for creating this opportunity.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, I thank my friend from Texas for yielding me this time.

Mr. Speaker, this is one of the most important issues that we are going to deal with in this Congress, how we provide patients protection in the health care system of this country. I am outraged, and I hope my colleagues are outraged, by the process that we are using in considering this legislation.

There have been no hearings on the Republican bill. It did not go through any of the committees of jurisdiction for the purpose of markup or to try to get the drafting done correctly, and no wonder that this bill is drafted so poorly. My Republican colleagues did not get it right. It is not going to do what they are advertising.

Let me just give one example. H.R. 815, which I introduced many, many months ago, deals with access to emergency care. We have 240 cosponsors of that legislation that adopts the prudent layperson standard so that an HMO has to reimburse a patient who should go to an emergency room. We passed it last year for Medicare and Medicaid, and yet the Republican bill does not get it right. It does not include pain. So if one has severe pain and reasonably should go to an emergency room, one's HMO can deny coverage. That is wrong. Even the HMOs acknowledge that pain is a reason to go to an emergency room. But my Republican colleagues did not put it in their bill and they did not allow a correction to be made. That is wrong.

Let me give another example. My Republican colleagues brag about an external appeal process, that they are giving the patients the right to take an

appeal, but what they are not saying is they did not get that right. The decision is not binding on the HMO. It is not independent. The HMO gets to select the people that serve on the panel. My Republican colleagues did not get it right.

There is legislation that has been filed that deals with external appeal, but my Republican colleagues did not bother taking it through the committees so that we could have that debate.

I urge my colleagues to adopt the bipartisan bill, which is our only chance today to provide meaningful patient protection.

Mr. GOSS. Mr. Speaker, I thank the distinguished gentleman from Maryland (Mr. CARDIN), my friend, who is indeed my close friend. I did not get it exactly right in describing our bill as the debate will show, but that is why we have the debate.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BOEHNER).

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

□ 1000

Mr. BOEHNER. Mr. Speaker, in just 3 years this Congress has delivered the first balanced budget in a generation, the first tax cuts from Washington in 16 years, and real reforms that are improving the lives of many who are on welfare today as they are able to move from welfare to work.

Today we are going to move in a bipartisan fashion to continue to add to our record of success and an opportunity to help the American people.

As I travel around my district, I have had many conversations with my constituents who are concerned about access to good-quality health care. As much as they want access, they are also concerned about making sure that it is affordable.

As I look at the two pieces of legislation that we are going to debate today, it is clear to me that the bill brought to us by the task force, headed by the gentleman from Illinois (Mr. DENNIS HASTERT), is a bill that does that. It empowers consumers, not lawyers. It makes sure that health care continues to be affordable and accessible for all Americans.

I think, in the end, that is what people want. They do not want to go to court. They want to be able to go to the doctor. They want to be able to get the treatments they need. And I think the empowerment that we see in our piece of legislation is exactly that.

The other bill that we will be debating, the proposal by the gentleman from Michigan, in fact creates an awful lot of big government, an awful lot of access to lawsuits and to lawyers and to courts, driving up the cost of health care. My greatest concern about the proposal from the gentleman from Michigan is that, by opening up employers to the lawsuit abuse that could occur, many employers in America are going to say we are not going to be pro-

viding health care coverage to our employees anymore.

I know myself, as a small employer, I would not continue to offer health care to my employees if I am subject to being sued by doctors, who may be on solid ground, maybe not. I am going to give them a voucher and let them go fight for their own.

I do not think that is what the American people want. They want reasonable access, reasonable cost to good-quality care.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from North Carolina (Mrs. CLAYTON).

(Mrs. CLAYTON asked and was given permission to revise and extend her remarks.)

Mrs. CLAYTON. Mr. Speaker, I thank the gentleman for yielding me this time.

When a child has a disease that can be cured, should the decision of whether to provide needed treatment be made by a doctor and the child's parents or by bureaucrats who are counting dollars and cents?

When a wife or mother has had a mastectomy and the procedure has not yet worn off, should she be forced to leave the hospital because of a rigid routine for saving dollars rather than saving lives?

When a husband and a father is unable to get prior approval from the insurance who he is paying for an emergency, should he be required to pay that medical bill himself?

When a grandfather is stricken with a life-threatening stroke, should the person transporting him be required to pass a hospital that is closest to him to go to one that is further away because a narrow-thinking person is more interested in saving dollars than, again, in saving lives?

H.R. 3605, which is the Patients' Bill of Rights, the Democrat substitute, indeed speaks to a number of basic rights that all of these patients that I just described should have and not have to suffer. The Republican bill, H.R. 4250, does not.

Many of the patient rights that we are talking about indeed does mean that a patient should have a right to sue. A patient should have a right to indeed hold us accountable for our liabilities and our rights. The patient should have a right to choose their doctor. A patient should have a right to choose other professionals that they desire.

H.R. 3605 does provide open communication. Although those on the other side say the gag clause is in there, I cannot find it. So I urge my colleagues to support the Patients' Bill of Rights, the Democratic substitute.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. WELDON), my colleague.

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding me this time.

As a physician who still practices medicine, I rise in strong support of

this rule. I have worked in managed-care settings and I have worked in fee-for-service settings. The important issue here is can we, in Washington, pass legislation that will help restore the doctor-patient relationship and, importantly, help restore quality health care within managed-care networks?

Now, my good friends on the Democrat side of the aisle have their bill; we have our bill. We are going to have a very interesting debate here this morning. I think the important issue, which speaks of how much better our Republican bill is, is the fact our bill is the bill that is not going to drive up costs, where the Democrat bill will; and, importantly, our bill is going to enable people who are uninsured to have access to health care and help them to more easily afford health care.

I would encourage all my colleagues to support this rule. Listen to the debate during general debate and the debate on the amendments and, in the end, I believe our bill is going to pass. Our bill is the better bill for restoring quality, for restoring the doctor-patient relationship, for reducing cost and giving the uninsured better access to health care.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. TURNER).

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

Mr. TURNER. Mr. Speaker, it has been suggested that the Republican bill is better, a better protection for patients. I submit to my colleagues that the Republican bill is worse protection for patients than exists in current law in most of our States.

I come from Texas. The Texas legislature passed patient protection legislation in 1977, fully intending that all HMOs be covered by the protections of State law.

The Republicans submit a bill today that would control patient protections at the Federal level. It would set out a set of rules that are far inferior to those in the Democratic alternative.

On the Republican bill, if the HMO denied coverage, the only remedy would be to go, if an individual is in a self-insured plan, to Federal Court. And when that individual gets there, they will not have a remedy.

In 1971, Phyllis Cannon was diagnosed with leukemia. She appealed to her HMO for a bone marrow transplant. The HMO refused. For over 40 days the HMO refused coverage. About a month after that, she died.

The court ruled that, under ERISA, she had no recovery. Under the Republican bill today, she would be entitled, her estate, to \$20,000, a small price for a life, the denial of treatment. Under the Republican bill, the penalty is \$500 a day. A much cheaper alternative for an HMO than providing the treatment that should have been provided to Phyllis Cannon.

I submit to my colleagues that every Member of this House needs to look at

what their State has done to protect patients, because a vote for the Republican bill is rolling back the protections that most of our States have already provided for patients under the law. In every place in this country, protecting patients enrolled in HMOs has been a bipartisan effort. Only in Washington is patient protection partisan.

Mr. GOSS. Mr. Speaker, may I ask for an accounting of the times again?

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida (Mr. GOSS) has 6 minutes remaining and the gentleman from Texas (Mr. FROST) has 3 minutes remaining.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the gentlewoman from Ohio (Ms. PRYCE), who is also a member of the task force as well as a member of leadership.

Ms. PRYCE of Ohio. Mr. Speaker, I thank my friend for yielding me this time, and I rise in strong support of this rule. And as a member of the working group on health care quality, I first want to thank our chairman, the gentleman from Illinois (Mr. DENNY HASTERT), for his patience and expertise and many hours of hard work that got us here today.

Mr. Speaker, the Patient Protection Act is the only managed care reform bill that goes beyond patient protection to address the issues of access and affordability of health care. Not only does this bill ban gag rules, provide emergency room access, and guaranty a choice of provider, it increases the number of people with insurance. It does that by helping small employers purchase affordable health benefits for their employees.

Now, it is nice to talk about quality. We all want the best health care we can get. But A-plus care does not help if we cannot afford to buy it. The Democrat proposal would price many, many people out of the market. We all know that more requirements, regulations, and government is not going to make insurance any cheaper. Rest assured, more government largess is just what we will get with the Democrat health bill.

Now, liability has become the rallying cry for the opponents of the Patient Protection Act. And the health care working group discussed this issue at length and came to some very rational conclusions. As a former judge, I think the solution we provide meets every legitimate goal of liability reform. The bottom line is that Americans pay a pretty sum for their health insurance and they expect it to cover the health care that they need when they need it. That is the crux of this debate.

Patients do not want bureaucrats denying their access to care; and when a claim is denied, patients want a quick remedy that relies on the opinion of a medical professional. But my Democratic colleagues would tell these dissatisfied patients that they must hire a lawyer and they send them off to court.

Mr. Speaker, what the Democrats fail to understand is that patients do not want a lawyer, a court date and expensive litigation. They want a doctor, a diagnosis, and treatment their doctor tells them that they need.

The Republican bill will get them that care by guaranteeing patient access to expedited review by independent medical experts. The Republican plan keeps patients out of court and in the health care system, and it requires the health plans to provide the coverage that they are promised.

The expedited appeals process in the Patient Protection Act gives patients the leverage they need to quickly get the care they deserve without going to court and waiting through years and years of litigation. I urge my colleagues to support patients, not lawyers' paychecks, and vote for this rule and the Republican Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, this is the real face of health care in America: A young boy who had a difficult birth and developed cerebral palsy. And at age 14 months the bureaucrats from the HMOs, the ones who are there just to ensure that those who need care do not get care, denied this young boy speech therapy and other kinds of therapies that he needed to have a better life.

Americans know the real deal. They understand what it means as they travel around this summer on vacation and something tragic happens and they go to an emergency room away from their State and that emergency room, because the HMO says they cannot come in, sends them away. They understand when a little one falls from a tree playing in the back yard and has pain; and the emergency room, because of the HMO, says no because all they have is pain as evidence of their injury and the HMO says pain is not enough.

I would say to my colleagues, Mr. Speaker, the real Bill of Rights is that of the Democrats, and that is what we need to support today. It is bipartisan, it is for real, it will the right health care coverage and the American people know the real thing.

Mr. FROST. Mr. Speaker, I yield the balance of my time to the gentleman from Maryland (Mr. HOYER).

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

Mr. HOYER. Mr. Speaker, the gentlewoman from Ohio (Ms. PRYCE) said what the Democrats know. Let me tell my colleagues what the Democrats know. When people commit wrongs, they do not want to be held accountable, and the Republicans are making sure that is true.

I rise today in opposition to H.R. 4250, the bill that my friends on the

other side of the aisle claim reforms managed care. The previous speaker, the chairman of their conference, said what the Republican Congress had brought as it pertains to a balanced budget. We will argue that some other time. The fact is, this Congress has not brought hardly anything to the American public.

□ 1015

It is the do-nothing Congress.

This bill is on the floor today because a discharge petition was signed by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) and about 190 others of us, and says, we want a health care reform bill on this floor. That is the reason it is here and the only reason we are here today.

I rise in strong support of the substitute offered by the gentleman from Iowa (Mr. GANSKE), a Republican and a doctor, and the gentleman from Michigan (Mr. DINGELL), the former Chairman of the Committee on Commerce, now Ranking Member, and the next Chairman of the Committee on Commerce.

The Republicans have chosen to support H.R. 4250, the so-called "Patient Protection Act." They bring this bill to the floor today with no hearings, no mark-ups, and no CBO estimate. In other words, they were so panicked by the discharge petition, that they brought it to the floor without the regular process.

Mr. Speaker, the American public wants access to health care. The American public wants decisions made by their doctors and by themselves, not by, as all of us have said, insurance companies. They are right. But the American public will not be fooled as to which alternative gives them protection, as to which bill gives them access, and as to which bill allows them to hold accountable those who undercut their health care protection.

My colleagues, I ask you to support the Democratic substitute, the Republican substitute, supported by Members on the other side of the aisle, the Ganske-Dingell substitute, supported by Members on the other side of the aisle, which does in fact do what everybody says they want to do.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this debate has been on the rule. Very clearly, we have not heard much concern about the rule, with some question about sensitivity by one speaker. But I do believe we have got a better process here than a discharge petition. And I think we will have a fair, longer, more extensive, complete, and deliberative debate at a result of this rule. And I do urge that everybody support it. I honestly do not think it is controversial in any way.

What we are doing today is responding to the call of all American people for improvements in our health care system but particularly for those who have no health care insurance. We are

not responding to the interests of any special groups or any special parties. And there are plenty of those who are asking for special attention. I think we have responded to America, to the people of America, who need health care.

We are doing this in the same spirit that we resolved the job lock and portability problems, the preexisting condition problems. We are doing this in same way that made the trust fund whole in Medicare. We are addressing the problems in our country in health care and we are doing it responsibly.

There has been a lot said and there will be a lot more said, and there clearly is much misinformation. I even read some misinformation in the Washington Post this morning, which has obviously misled some of the speakers who have addressed this during this rule.

It is very clear that we have made a good bill, and it is very clear that not everybody understands it yet. It is also very clear that the Patient Protection Act does not have any big brother in it. There is no big brother in our bill. In fact, we put a halt to the big brother ID system that has been recently discussed and that so many Americans find extremely distasteful and an invasion of their privacy.

I think that many portions of the legislation that we have, as virtually everybody knows that is tuned into this, have already been through appropriate committees and they have been I think well put together and much debated.

I think the critical point probably is that what we have done in this bill is cut into the 42 million Americans, that big pool of people who do not have health care insurance, and given them the opportunity to get it.

The bill on the other side, the Dingle-Kennedy bill, adds, according to CBO, to the pool of Americans who will not have health care insurance. That is simply unacceptable. Accessibility to health care insurance is critical.

I want to close on a note that many will recognize. My wife and I experienced something this year that every parent dreads, a seriously sick youngster coming in and asking for health care and the plan that that child was under could not perform. I personally got involved with why and what went wrong.

So when I speak to my colleagues to say that I think we have a fix in the patient protection care, I speak to them as a parent, not as a legislator. I assure my colleagues, I would not be supporting this legislation if I did not think my sick youngster would be better off under this plan.

I urge support of this rule.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered. The SPEAKER pro tempore (Mr. LAHOOD). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. FROST. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 279, nays 143, not voting 12, as follows:

[Roll No. 335]

YEAS—279

Aderholt
Archer
Army
Bachus
Baesler
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Billey
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bono
Boswell
Boyd
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Chabot
Chambliss
Christensen
Clayton
Clement
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Cramer
Crane
Crapo
Cubin
Cummings
Cunningham
Danner
Davis (VA)
Deal
DeGette
Delahunt
DeLay
Diaz-Balart
Dickey
Dingell
Doyle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Etheridge
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox

Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Greenwood
Gutknecht
Hall (TX)
Hamilton
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Hefner
Hill
Hilleary
Hobson
Hoekstra
Holden
Hooley
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Jackson-Lee
(TX)
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kanjorski
Kasich
Kasich
Kelly
Kennedy (MA)
Kennelly
Kildee
Kilpatrick
Kim
Kind (WI)
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Lucas
Manton
Manzullo
Mascara
McCarthy (MO)
McCarthy (NY)
McCollum
McCrery

McDade
McHugh
McInnis
McIntosh
McIntyre
McKeon
Metcalf
Mica
Millender-
McDonald
Miller (FL)
Mollohan
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Obey
Ortiz
Oxley
Packard
Pallone
Pappas
Parker
Pascrell
Pastor
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Redmond
Regula
Regula
Riggs
Riley
Rivers
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Royce
Ryun
Salmon
Sanford
Sawyer
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherman
Shimkus
Shuster
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)

Smith, Adam
Smith, Linda
Snowbarger
Snyder
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin

Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traficant
Upton
Walsh
Wamp
Watkins
Watts (OK)

NAYS—143

Abercrombie
Ackerman
Allen
Andrews
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Bonior
Borski
Boucher
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Carson
Castle
Clay
Clyburn
Condit
Conyers
Costello
Coyne
Davis (FL)
Davis (IL)
DeFazio
DeLauro
McDermott
Dicks
Dixon
Doggett
Dooley
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Filner
Forbes
Frank (MA)

Furse
Gejdenson
Gephardt
Green
Hall (OH)
Harman
Hastings (FL)
Hilliard
Hinchey
Hinojosa
Hoyer
Istook
Jackson (IL)
John
Johnson (WI)
Johnson, E.B.
Kaptur
Kennedy (RI)
Kleczka
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lowey
Luther
Maloney (CT)
Maloney (NY)
Martinez
Matsui
McDermott
McGovern
McHale
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Miller (CA)
Watt (NC)
Mink
Moakley
Nadler
Neal

NOT VOTING—12

Chenoweth
Doolittle
Ford
Gonzalez

Gutierrez
Herger
Jefferson
Markey

□ 1040

Mr. RANGEL and Mr. MENENDEZ changed their vote from "yea" to "nay."

Ms. LOFGREN, Mrs. MCCARTHY of New York, Mr. BILIRAKIS and Mr. CRAMER changed their vote from "nay" to "yea."

So the resolution was agreed to. The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. HASTERT. Mr. Speaker, pursuant to House Resolution 509, I call up the bill (H.R. 4250) to provide new patient protections under group health plans, and ask for its immediate consideration in the House.

The Clerk read the title of the bill. The SPEAKER pro tempore (Mr. KOLBE). The bill is considered read for amendment.

The text of H.R. 4250 is as follows:

H.R. 4250

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) **SHORT TITLE.**—The Act may be cited as the "Patient Protection Act of 1998".

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

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections.

Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising under Group Health Plans

Sec. 1201. Special rules for group health plans

Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Sec. 1301. Short title of subtitle.

Sec. 1302. 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. Special rules for church plans.

"Sec. 813. Definitions and rules of construction.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Reporting on fraud and abuse enforcement activities.

Sec. 2103. Effective date.

Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

"TITLE XXVIII—HEALTHMARTS

"Sec. 2801. Definition of HealthMart.

"Sec. 2802. Application of certain laws and requirements.

"Sec. 2803. Administration.

"Sec. 2804. Definitions.

SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Reporting on fraud and abuse enforcement activities.

Sec. 3103. Effective date.

Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 4011. Statute of limitations.

Sec. 4012. Calculation and payment of damages.

Sec. 4013. Alternative dispute resolution.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Sec. 5001. Confidentiality of protected health information.

"PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

"Sec. 1181. Inspection and copying of protected health information.

"Sec. 1182. Supplementation of protected health information.

"Sec. 1183. Notice of confidentiality practices.

"Sec. 1184. Establishment of safeguards.

"Sec. 1185. Availability of protected health information for purposes of health care operations.

"Sec. 1186. Relationship to other laws.

"Sec. 1187. Civil penalties.

"Sec. 1188. Definitions.

Sec. 5002. Study and report on effect of State law on health-related research.

Sec. 5003. Study and report on State law on protected health information.

Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

Sec. 6001. Medical savings accounts for Federal employees.

Sec. 6002. Effective date.

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

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

(a) **IN GENERAL.**—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended further by adding at the end the following new sections:

"SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

"(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

"(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

"(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

“(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

“(A) the plan or issuer shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

“(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

“(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

“(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

“(A) provides benefits under the terms of the plan consisting of—

“(i) routine gynecological care (such as preventive women’s health examinations), or

“(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

“(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of paragraph (2).

“(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

“(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

“(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

“(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of cov-

erage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

“(d) PATIENT ACCESS TO PEDIATRIC CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

“(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.”

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

“Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.”

SEC. 1002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

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

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

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

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers,

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers,

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers,

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers, or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider, or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

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

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

“DISCLOSURE BY GROUP HEALTH PLANS

“SEC. 111. (a) DISCLOSURE REQUIREMENT.—

“(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

“(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

“(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

“(1) COVERED ITEMS AND SERVICES.—

“(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

“(i) types of items and services (including any special disease management program), and

“(ii) types of health care professionals providing such items and services.

“(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

“(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

“(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

“(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

“(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

“(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

“(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

“(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

“(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

“(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for

second or subsequent opinions is limited or excluded.

“(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

“(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

“(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

“(C) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

“(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

“(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

“(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

“(1) descriptions thereof relating specifically to—

“(A) coverage decisions,

“(B) internal review of coverage decisions, and

“(C) any external review of coverage decisions, and

“(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

“(e) INFORMATION AVAILABLE ON REQUEST.—

“(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

“(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications; and

“(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

“(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

“(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

“(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

“(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

“(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

“(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any

health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

“(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility’s corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

“(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

“(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

“(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

“(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

“(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

“(4) by any other reasonable means of timely informing plan participants.

“(h) DEFINITIONS.—For purposes of this section—

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided such term under section 503(b)(6).

“(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided such term under section 733(a)(2).

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

“(4) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided such term under section 733(b)(2).”

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking “section 733(a)(1)” each place it appears and inserting “section 503(b)(6)”; and

(B) by inserting before the period at the end the following: “; and, in the case of a

group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)”.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

“Sec. 111. Disclosure by group health plans.
“Sec. 112. Repeal and effective date.”

SEC. 1102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

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

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting “(a) IN GENERAL.—” after “SEC. 503.”;

(2) by inserting “(other than a group health plan)” after “employee benefit plan”; and

(3) by adding at the end the following new subsection:

“(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

“(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

“(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the participant,

“(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

“(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named fiduciary who did not make the initial decision, and

“(D) meet the additional requirements of this subsection.

“(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

“(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

“(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

“(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

“(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

“(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

“(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

“(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

“(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including

issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for the decision—

“(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

“(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

“(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

“(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

“(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

“(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

“(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

“(I) does not meet the plan's requirements for medical appropriateness or necessity, or

“(II) would constitute experimental treatment or technology.

“(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

“(i) the lesser of \$100 or 10 percent of the cost of the medical care involved in the decision, or

“(ii) \$25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, sole-

ly for such calendar year, to be equal to such amount rounded to the nearest \$10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

“(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

“(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

“(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record,

“(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

“(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

“(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

“(E) INDEPENDENT MEDICAL EXPERTS.—

“(i) IN GENERAL.—For purposes of this paragraph, the term ‘independent medical expert’ means, in connection with any coverage decision by a group health plan, a professional—

“(I) who is a physician or, if appropriate, another medical professional,

“(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

“(III) who was not involved in the initial decision or any earlier review thereof, and

“(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

“(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

“(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert,

“(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

“(III) the expert is selected by an organization described in section 1152(I)(A) of the Social Security Act which meets the requirements of clause (iii),

“(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

“(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (iii).

“(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

“(I) the expert or entity is not affiliated with any related party,

“(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

“(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

“(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

“(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term ‘related party’ means—

“(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

“(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

“(III) the institution at which the medical care involved in the coverage decision is provided,

“(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

“(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

“(v) AFFILIATED.—For purposes of clause (iii)(I), the term ‘affiliated’ means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

“(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED

FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

“(i) does not meet the plan’s requirements for medical appropriateness or necessity, or

“(ii) would constitute experimental treatment or technology (as defined under the plan).

“(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

“(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

“(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

“(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

“(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

“(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

“(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

“(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

“(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

“(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

“(A) the plan agrees in advance of the recommendations of the independent medical

expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations, and

“(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

“(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.—In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term ‘specialist’ means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

“(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

“(A) IN GENERAL.—The term ‘group health plan’ shall have the meaning provided in section 733(a).

“(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

“(9) OTHER DEFINITIONS.—For purposes of this subsection—

“(A) REQUEST FOR BENEFIT PAYMENTS.—The term ‘request for benefit payments’ means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

“(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term ‘required determination of medical necessity’ means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan’s requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

“(C) ADVANCE DETERMINATION OF COVERAGE.—The term ‘advance determination of coverage’ means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan’s terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

“(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term ‘request for advance determination of coverage’ means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

“(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term ‘request for expedited advance determination of coverage’ means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

“(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term ‘request for required determination of medical necessity’ means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

“(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term ‘request for expedited required determination of medical necessity’ means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

“(H) URGENT MEDICAL CARE.—The term ‘urgent medical care’ means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

“(i) the imminent death of the participant or beneficiary, or

“(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

“(I) EMERGENCY MEDICAL CARE.—The term ‘emergency medical care’ means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

“(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

“(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(II) serious impairment to bodily functions, or

“(III) serious dysfunction of any bodily organ or part,

or

“(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

“(J) INITIAL DECISION PERIOD.—The term ‘initial decision period’ means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

“(K) INTERNAL REVIEW PERIOD.—The term ‘internal review period’ means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

“(L) URGENT DECISION PERIOD.—The term ‘urgent decision period’ means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

“(M) EMERGENCY DECISION PERIOD.—The term ‘emergency decision period’ means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

“(N) SPECIALTY DECISION PERIOD.—The term ‘specialty decision period’ means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

“(O) RECONSIDERATION PERIOD.—The term ‘reconsideration period’ means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

“(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

“(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

“(P) FILING COMPLETION DATE.—The term ‘filing completion date’ means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in

such other reasonable form as may be specified by the plan) to make an initial coverage decision.

“(Q) REVIEW FILING DATE.—The term ‘review filing date’ means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

“(R) MEDICAL CARE.—The term ‘medical care’ has the meaning provided such term by section 733(a)(2).

“(S) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided such term by section 733(b)(1).

“(T) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided such term by section 733(b)(2).

“(U) WRITTEN OR IN WRITING.—

“(i) IN GENERAL.—A request or decision shall be deemed to be ‘written’ or ‘in writing’ if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

“(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.”.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

“(6)(A)(i) In any case in which—

“(1) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

“(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court’s discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

“(ii) Such civil penalty shall be in the amount of up to \$250 a day from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed \$100,000.

“(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable

coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

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

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

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

“(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of one or more group health plans (as defined in section 503(b)(8)) for—

“(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

“(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

“(ii) Such penalty shall be in an amount not to exceed the lesser of—

“(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

“(II) \$100,000.

“(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.”.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking “(6)” and inserting “(7)”.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking “or” at the end;

(2) in subsection (a)(9), by striking the period and inserting “; or”;

(3) by adding at the end of subsection (a) the following new paragraph:

“(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).”.

(4) by adding at the end of subsection (b) the following new paragraph:

“(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.”.

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security

Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking “under subsection (a)(1)(B) of this section” and inserting “under subsection (a)(1)(A) for relief under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)”;

(2) in the last sentence, by striking “of actions under paragraphs (1)(B) and (7) of subsection (a) of this section” and inserting “of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)”.

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the “Small Business Affordable Health Coverage Act of 1998”.

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

“(a) IN GENERAL.—For purposes of this part, the term ‘association health plan’ means a group health plan—

“(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

“(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

“(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

“(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for

periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care.

“(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

“(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

“(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

“(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

“(1) such certification—

“(A) is administratively feasible,

“(B) is not adverse to the interests of the individuals covered under the plan, and

“(C) is protective of the rights and benefits of the individuals covered under the plan, and

“(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

“(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

“(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

“(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

“SEC. 803. REQUIREMENTS RELATING TO SPONSOR AND BOARDS OF TRUSTEES.

“(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

“(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

“(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

“(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

“(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

“(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

“(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

“(B) LIMITATION.—

“(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

“(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

“(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

“(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

“(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

“(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

“(2) the requirements of section 804(a)(1) shall be deemed met.

“(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

“(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

“(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

“(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

“(C) the requirements of section 804 shall be deemed met.

“(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

“(A) the plan is a multiemployer plan, or

“(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

“(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

“(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

“(2) all individuals commencing coverage under the plan after certification under this part must be—

“(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

“(B) the beneficiaries of individuals described in subparagraph (A).

“(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

“(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

“(A) the affiliated member was an affiliated member on the date of certification under this part, or

“(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

“(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

“(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

“(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

“(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating

employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer.

“(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

“(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

“(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

“(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

“(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

“(C) incorporates the requirements of section 806.

“(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—

“(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

“(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

“(i) setting contribution rates based on the claims experience of the plan, or

“(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market,

subject to the requirements of section 702(b) relating to contribution rates.

“(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

“(4) MARKETING REQUIREMENTS.—

“(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

“(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term ‘State-licensed insurance agents’ means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

“(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

“(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this

part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

“(1) the benefits under the plan consist solely of health insurance coverage, or

“(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

“(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

“(i) a reserve sufficient for unearned contributions,

“(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

“(iii) a reserve sufficient for any other obligations of the plan, and

“(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan, and

“(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

“(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than \$200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

“(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this

subsection are met if the plan establishes and maintains surplus in an amount at least equal to \$2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than \$500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

“(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

“(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

“(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

“(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

“(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

“(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of \$5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

“(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

“(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

“(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is,

or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

“(3) ASSOCIATION HEALTH PLAN FUND.—

“(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

“(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

“(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

“(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term ‘aggregate excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

“(B) which is guaranteed renewable, and

“(C) which allows for payment of premiums by any third party on behalf of the insured plan.

“(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term ‘specific excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual,

“(B) which is guaranteed renewable, and

“(C) which allows for payment of premiums by any third party on behalf of the insured plan.

“(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term ‘indemnification insurance’ means, in connection with an association health plan, a contract—

“(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

“(2) which is guaranteed renewable and noncancellable for any reason (except as

may be provided in regulations of the applicable authority), and

“(3) which allows for payment of premiums by any third party on behalf of the insured plan.

“(i) RESERVES.—For purposes of this section, the term ‘reserves’ means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as may be prescribed in regulations of the applicable authority.

“(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

“(1) a representative of the National Association of Insurance Commissioners,

“(2) a representative of the American Academy of Actuaries,

“(3) a representative of the State governments, or their interests,

“(4) a representative of existing self-insured arrangements, or their interests,

“(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

“(6) a representative of multiemployer plans that are group health plans, or their interests.

“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

“(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of \$5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

“(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

“(1) IDENTIFYING INFORMATION.—The names and addresses of—

“(A) the sponsor, and

“(B) the members of the board of trustees of the plan.

“(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

“(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

“(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any by-laws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

“(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

“(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit op-

tions determined as of a date within the 120-day period ending with the date of the application, including the following:

“(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

“(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

“(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan’s administrative expenses and claims.

“(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

“(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

“(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

“(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

“(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

“(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association

health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

“(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

“(2) represent such actuary's best estimate of anticipated experience under the plan. The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

“Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

“(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

“(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

“(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

“(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

“(b) MANDATORY TERMINATION.—In any case in which—

“(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

“(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

“(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

“(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

“(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

“(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

“(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

“(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

“(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

“(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

“(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

“(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship,

“(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

“(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

“(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

“(1) the sponsor and plan administrator,

“(2) each participant,

“(3) each participating employer, and

“(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

“(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

“(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

“(f) JURISDICTION OF COURT.—

“(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

“(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

“(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

“SEC. 811. STATE ASSESSMENT AUTHORITY.

“(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the

date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

“(b) CONTRIBUTION TAX.—For purposes of this section, the term ‘contribution tax’ imposed by a State on an association health plan means any tax imposed by such State if—

“(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

“(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

“(3) such tax is otherwise nondiscriminatory, and

“(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

“(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

“(b) EFFECT OF ELECTION.—

“(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

“(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

“(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

“(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

“(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of sub-

sections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

“(4) DEFINITIONS.—For purposes of this section—

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

“(B) STATE.—The term ‘State’ includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

“(C) REQUIREMENTS FOR COVERED CHURCH PLANS.—

“(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

“(A) for the exclusive purpose of:

“(i) providing benefits to participants and their beneficiaries; and

“(ii) defraying reasonable expenses of administering the plan;

“(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

“(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

“(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

“(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

“(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

“(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

“(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

“(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

“(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

“(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

“(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

“(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with

the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

“(C) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

“(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

“(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

“(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

“(a) DEFINITIONS.—For purposes of this part—

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

“(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided in section 733(a)(2).

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

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

“(5) APPLICABLE AUTHORITY.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘applicable authority’ means, in connection with an association health plan—

“(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

“(ii) if there is no State referred to in clause (i), the Secretary.

“(B) EXCEPTIONS.—

“(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

“(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i),

section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

“(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

“(7) INDIVIDUAL MARKET.—

“(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

“(B) TREATMENT OF VERY SMALL GROUPS.—

“(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

“(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

“(8) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

“(9) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

“(10) QUALIFIED ACTUARY.—The term ‘qualified actuary’ means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

“(11) AFFILIATED MEMBER.—The term ‘affiliated member’ means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

“(12) LARGE EMPLOYER.—The term ‘large employer’ means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

“(13) SMALL EMPLOYER.—The term ‘small employer’ means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

“(b) RULES OF CONSTRUCTION.—

“(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

“(A) in the case of a partnership, the term ‘employer’ (as defined in section (3)(5)) in-

cludes the partnership in relation to the partners, and the term ‘employee’ (as defined in section (3)(6)) includes any partner in relation to the partnership, and

“(B) in the case of a self-employed individual, the term ‘employer’ (as defined in section 3(5)) and the term ‘employee’ (as defined in section 3(6)) shall include such individual.

“(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.”

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

“(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.”

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (d)”;

(B) in subsection (b)(5), by striking “subsection (a)” in subparagraph (A) and inserting “subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

“(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

“(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

“(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

“(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

“(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

“(4) For purposes of this subsection, the term ‘association health plan’ has the meaning provided in section 801(a), and the terms ‘health insurance coverage’, ‘participating employer’, and ‘health insurance issuer’ have the meanings provided such terms in section 811, respectively.”

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking “and” at the end;

(B) in clause (ii), by inserting “and which does not provide medical care (within the meaning of section 733(a)(2)),” after “arrangement,” and by striking “title.” and inserting “title, and”; and

(C) by adding at the end the following new clause:

“(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.”

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking “Nothing” and inserting “(1) Except as provided in paragraph (2), nothing”; and

(B) by adding at the end the following new paragraph:

“(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.”

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: “Such term also includes a person serving as the sponsor of an association health plan under part 8.”

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: “An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.”

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting “or part 8” after “this part”.

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

"Sec. 809. Corrective actions and mandatory termination.

"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

"Sec. 811. State assessment authority.

"Sec. 812. Special rules for church plans.

"Sec. 813. Definitions and rules of construction."

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement;" after "single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "control group";

(2) in clause (iii)—

(A) by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 percent may not be required as the minimum interest necessary for common control"; and

(B) by striking "similar to" and inserting "consistent and coextensive with";

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement."

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

"(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E)."

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

"(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

"(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

"(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organiza-

tion (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

"(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

"(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

"(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

"(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

"(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

"(ii)(I) the plan or arrangement is a multi-employer plan; and

"(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

"(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

"(ii) the employee organization or other entity sponsoring the plan or arrangement—

"(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

"(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement."

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: "Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii)."

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "SEC. 501."; and

(2) by adding at the end the following new subsection:

"(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

"(1) being an association health plan which has been certified under part 8;

"(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

"(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met; shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both."

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(n)(I) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

"(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

"(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

"(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

"(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

"(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

"(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan."

(C) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

"(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan."

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

"(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

"(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

"(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

"(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

"(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

"(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained."

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an ar-

angement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms "group health plan," "medical care," and "participating employer" shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "association health plan" shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction;

dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term "pilot program period" means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

"(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

"(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

"(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

"(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

"(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

"(A) the plan or issuer shall provide benefits, without requiring preauthorization, for

appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

“(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

“(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

“(C) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

“(A) provides benefits under the terms of the plan consisting of—

“(i) routine gynecological care (such as preventive women's health examinations), or

“(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

“(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of paragraph (2).

“(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

“(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

“(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

“(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

“(D) PATIENT ACCESS TO PEDIATRIC CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits

consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

“(E) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.”

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

“SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

“(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

“(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

“(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclu-

sively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

“(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

“(c) EXCEPTIONS.—

“(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

“(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

“(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

“(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

“(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently than once every two years.

“(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the

class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently than once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

“(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

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

“(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

“(2) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ has the meaning given such term in section 2706(a)(2).”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A of this title) is amended further by adding at the end the following new section:

“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

“(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act) for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

“(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

“(1) COVERED ITEMS AND SERVICES.—

“(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

“(i) types of items and services (including any special disease management program), and

“(ii) types of health care professionals providing such items and services.

“(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

“(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

“(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

“(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

“(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

“(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

“(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

“(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

“(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

“(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

“(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan’s requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

“(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

“(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

“(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

“(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

“(c) PARTICIPANT’S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

“(1) a participant’s financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

“(2) the circumstances under which, and the extent to which, the participant’s financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

“(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

“(1) descriptions thereof relating specifically to—

“(A) coverage decisions,

“(B) internal review of coverage decisions, and

“(C) any external review of coverage decisions, and

“(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

“(e) INFORMATION AVAILABLE ON REQUEST.—

“(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

“(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications, and

“(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

“(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

“(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or

programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

“(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

“(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

“(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

“(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

“(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

“(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a

health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

“(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

“(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

“(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

“(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

“(4) by any other reasonable means of timely informing plan participants.”.

SEC. 2102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys with the guideline entitled “Guidance on the Use of the False Claims Act in Civil Health Care Matters” issued by the Department on June 3, 1998, including any revisions to such guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled “National Project Protocols—Best Practice Guidelines” issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce of the House of Representatives not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 2103. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the “Health Care Consumer Empowerment Act of 1998”.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

The Public Health Service Act is amended by adding at the end the following new title:

“TITLE XXVIII—HEALTHMARTS

“SEC. 2801. DEFINITION OF HEALTHMART.

“(a) IN GENERAL.—For purposes of this title, the term ‘HealthMart’ means a legal entity that meets the following requirements:

“(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

“(A) Small employers.

“(B) Employees of small employers.

“(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

“(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

“(2) OFFERING HEALTH BENEFITS COVERAGE.—

“(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

“(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

“(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

“(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

“(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

“(3) GEOGRAPHIC AREAS.—

“(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

“(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

“(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this

title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

"(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

"(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

"(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

"(6) FILING INFORMATION.—The HealthMart—

"(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

"(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

"(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

"(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

"(A) be underwritten by a health insurance issuer that—

"(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a)),

"(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

"(iii) offers the coverage under a contract with the HealthMart;

"(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

"(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

"(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

"(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

"(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

"(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

"(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

"(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

"(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

"(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

"(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

"(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

"(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

"(A) Coverage through a health maintenance organization.

"(B) Coverage in connection with a preferred provider organization.

"(C) Coverage in connection with a licensed provider-sponsored organization.

"(D) Indemnity coverage through an insurance company.

"(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

"(F) Coverage that includes a point-of-service option.

"(G) Coverage offered by a community health organization (as defined in section 330B(e)).

"(H) Any combination of such types of coverage.

"(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease

prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

"(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

"(1) PURCHASERS.—

"(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

"(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

"(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

"(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

"(2) MEMBERS.—

"(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

"(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

"(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

"(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

"(3) HEALTH INSURANCE ISSUERS.—

"(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a

member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

“(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

“(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

“(d) PREVENTION OF CONFLICTS OF INTEREST.—

“(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

“(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

“(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

“(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

“(B) CONSTRUCTION.—For purposes of subparagraph (A), the term “affiliated” does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

“(e) CONSTRUCTION.—

“(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

“(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

“(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

“(i) a change of employers through which the coverage is provided, or

“(ii) a change in place of employment to an area not served by the previous HealthMart.

“(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

“(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

“(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

“(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

“(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

“(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

“(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

“(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

“(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

“(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

“(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

“(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

“(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

“(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by

a health insurance issuer through a HealthMart.

“(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

“(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

“(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

“(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

“(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

“SEC. 2803. ADMINISTRATION.

“(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of ‘deemed file and use’ with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

“(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

“(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

“(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

“(A) oversight of the operations of HealthMarts under this title; and

“(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

“(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the

rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

“SEC. 2804. DEFINITIONS.

“For purposes of this title:

“(1) APPLICABLE FEDERAL AUTHORITY.—The term ‘applicable Federal authority’ means the Secretary of Health and Human Services.

“(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term ‘eligible’ means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

“(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms ‘employer’, ‘employee’, and ‘dependent’, as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

“(4) HEALTH BENEFITS COVERAGE.—The term ‘health benefits coverage’ has the meaning given the term group health insurance coverage in section 2791(b)(4).

“(5) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

“(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning given such term in section 2791(d)(9).

“(7) HEALTHMART.—The term ‘HealthMart’ is defined in section 2801(a).

“(8) MEMBER.—The term ‘member’ means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

“(9) PURCHASER.—The term ‘purchaser’ means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

“(10) SMALL EMPLOYER.—The term ‘small employer’ has the meaning given such term for purposes of title XXVII.”

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

“WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

“SEC. 330B. (a) WAIVER AUTHORIZED.—

“(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

“(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) by not later than November 1, 2003, and

“(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in sub-

paragraph (A), (B), or (C) of paragraph (2) has been met.

“(2) GROUNDS FOR APPROVAL OF WAIVER.—

“(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State’s receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

“(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

“(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization’s failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

“(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

“(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

“(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

“(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization’s compliance with the requirements described in paragraph (5).

“(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

“(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

“(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization’s compliance with all consumer protection and quality standards insofar as such standards—

“(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

“(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

“(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

“(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

“(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

“(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

“(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

“(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

“(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

“(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

“(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

“(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

“(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

“(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

“(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

“(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

“(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

“(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

“(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

“(e) DEFINITIONS.—In this section:

“(1) COMMUNITY HEALTH ORGANIZATION.—The term ‘community health organization’ means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

“(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term ‘Federally-qualified health center’ has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

“(3) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning given such term in section 2791(b)(1).

“(4) CONTROL.—The term ‘control’ means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.”

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

“SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

“(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan, the plan with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, re-

gardless of whether benefits for such care or treatment are provided under the plan.

“(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ‘health care professional’ means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

“(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

“(A) the plan shall provide benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

“(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

“(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including co-insurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

“(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

“(1) IN GENERAL.—In any case in which a group health plan—

“(A) provides benefits under the terms of the plan consisting of—

“(i) routine gynecological care (such as preventive women's health examinations), or

“(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

“(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan shall meet the requirements of paragraph (2).

“(2) REQUIREMENTS.—A group health plan meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan—

“(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

“(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

“(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

“(d) PATIENT ACCESS TO PEDIATRIC CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

“(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.”

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

“Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.”

SEC. 3002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs before the date of issuance of regulations issued in connection with such requirement if the plan has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of

the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 102 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section: “SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

“(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance coverage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

“(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

“(1) COVERED ITEMS AND SERVICES.—

“(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

“(i) types of items and services (including any special disease management program), and

“(ii) types of health care professionals providing such items and services.

“(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

“(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

“(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

“(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

“(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

“(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

“(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether

coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

“(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

“(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

“(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan’s requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

“(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

“(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

“(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

“(c) PARTICIPANT’S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

“(1) a participant’s financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

“(2) the circumstances under which, and the extent to which, the participant’s financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

“(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

“(1) descriptions thereof relating specifically to—

“(A) coverage decisions,

“(B) internal review of coverage decisions, and

“(C) any external review of coverage decisions, and

“(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

“(e) INFORMATION AVAILABLE ON REQUEST.—

“(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

“(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications; and

“(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

“(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

“(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

“(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

“(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any

preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

“(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

“(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

“(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility’s corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

“(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

“(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

“(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

“(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

“(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

“(4) by any other reasonable means of timely informing plan participants.”.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

“Sec. 9814. Disclosure by group health plans.”

SEC. 3102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys with the guideline entitled “Guidance on the Use of the False Claims Act in Civil Health Care Matters” issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled “National Project Protocols—Best Practice Guidelines” issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on the Judiciary and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 3103. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of the Treasury or the Secretary’s delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(ii) of such Code (defining eligible individual) is amended by striking “and such employer is a small employer”.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to ½ of the annual deductible (as of the first day of such month) of the taxpayer’s coverage under the high deductible health plan.”

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking “75 percent of”.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

“(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includable in the taxpayer’s gross income for such taxable year.”

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking “\$1,500” and inserting “\$1,000”, and

(B) by striking “\$3,000” and inserting “\$2,000”.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking “1998” and inserting “1999”, and

(B) by striking “1997” and inserting “1998”.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking “106(b).”.

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

“(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

“(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

“(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

“(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

“(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I).”

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

“(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

“(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined

in section 330(b)(1)(A) of such Act) provided on a capitated basis.

“(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

“(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year.”

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking “and” at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting “; and”, and

(3) by inserting after subparagraph (L) the following new subparagraph:

“(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be required by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section.”

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of \$50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term “actual damages” means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term “claimant” means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term “clear and convincing evidence” is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term “collateral source payments” means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term “drug” has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term “economic loss” means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term “harm” means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term “health benefit plan” means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term “health care liability action” means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term “health care liability claim” means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term “health care provider” means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term “health care service” means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term “medical device” has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NON-ECONOMIC DAMAGES.—The term “non-economic damages” means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term “person” means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term “product seller” means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term “punitive damages” means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter

such person or others from engaging in similar behavior in the future.

(19) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed \$250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State

law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or
(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds \$50,000, a person shall not be required to pay such damages in a single, lump-sum

payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

"PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

"INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

"SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

"(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

"(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that

was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v-1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

"(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

"(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

"(2) the information is compiled principally—

"(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

"(B) for use in such action or proceeding.

"(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

"(1) the reasons for the denial of the request;

"(2) the availability of procedures for further review of the denial; and

"(3) the individual's right to file with the person a concise statement setting forth the request.

"(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

"(1) shall include a notation concerning the individual's statement; and

"(2) may include a concise statement of the reasons for denying the request for inspection or copying.

"(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section may set forth appropriate procedures to be followed for such inspection or copying and may require an individual to pay reasonable costs associated with such inspection or copying.

"(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

"(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

"(j) RULES GOVERNING AGENTS.—An agent of a person described in subsection (a) shall not be required to provide for the inspection and copying of protected health information, except where—

"(1) the protected health information is retained by the agent; and

"(2) the agent has been asked by the person to fulfill the requirements of this section.

"SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

"SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after

the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

"(1) shall make the amendment requested;

"(2) shall inform the individual of the amendment that has been made; and

"(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

"(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested by an individual under such subsection, the person shall inform the individual, in writing, of—

"(1) the reasons for the refusal to make the amendment;

"(2) any procedures for further review of the refusal; and

"(3) the individual's right to file with the person a concise statement setting forth the requested amendment and the individual's reasons for disagreeing with the refusal.

"(c) STATEMENT OF DISAGREEMENT.—If an individual has filed a statement of disagreement with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

"(1) shall include a notation that such individual has filed a statement of disagreement; and

"(2) may include a concise statement of the reasons for not making the requested amendment.

"(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

"(1) the information is retained by the agent; and

"(2) the agent has been asked by such person to fulfill the requirements of this section.

"(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—If a person described in subsection (a) receives a duplicative request for an amendment of information as provided for in such subsection and a statement of disagreement with respect to the request has been filed pursuant to subsection (c), the person shall inform the individual of such filing and shall not be required to carry out the procedures under this section.

"(f) RULE OF CONSTRUCTION.—This section shall not be construed—

"(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

"(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

"NOTICE OF CONFIDENTIALITY PRACTICES

"SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

"(1) a description of an individual's rights with respect to protected health information;

"(2) the intended uses and disclosures of protected health information;

"(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

"(4) the procedures established by the person for obtaining copies of the notice.

"(b) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

"ESTABLISHMENT OF SAFEGUARDS

"SEC. 1184. (a) IN GENERAL.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by the person.

"(b) FACTORS TO BE CONSIDERED.—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

"(1) The need for protected health information.

"(2) The categories of personnel who will have access to protected health information.

"(3) The feasibility of limiting access to individual identifiers.

"(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

"(5) The value of audit trails in computerized records.

"(c) RELATIONSHIP TO PART C REQUIREMENT.—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

"(d) CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into non-identifiable health information.

"AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS

"SEC. 1185. DISCLOSURE.—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

"(b) USE.—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

"RELATIONSHIP TO OTHER LAWS

"SEC. 1186. (a) STATE LAW.—

"(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

"(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

“(B) relates to authorization for the use or disclosure of—

“(i) protected health information for health care operations; or

“(ii) nonidentifiable health information; or

“(C) relates to any of the following:

“(i) Inspection or copying of protected health information by a person who is a subject of the information.

“(ii) Amendment of protected health information by a person who is a subject of the information.

“(iii) Notice of confidentiality practices with respect to protected health information.

“(iv) Establishment of safeguards for protected health information.

“(2) EXCEPTIONS.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

“(A) the confidentiality of the records maintained by a licensed mental health professional;

“(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

“(C) condition-specific limitations on disclosure;

“(D) the use or disclosure of information for use in legally authorized—

“(i) disease or injury reporting;

“(ii) public health surveillance, investigation, or intervention;

“(iii) vital statistics reporting, such as reporting of birth or death information;

“(iv) reporting of abuse or neglect information;

“(v) reporting of information concerning a communicable disease status; or

“(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

“(E) the disclosure to a person by a health care provider of information about an individual, in any case in which the provider has determined—

“(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

“(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

“(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

“(3) PRIVILEGES.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

“(b) FEDERAL LAW.—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

“CIVIL PENALTIES

“SEC. 1187. (a) VIOLATION.—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any

other penalties that may be prescribed by law—

“(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than \$500 for each such violation but not to exceed \$5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

“(2) in the case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than \$10,000 for each such violation, but not to exceed \$50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

“(3) in a case in which the Secretary finds that such violations have occurred with such frequency as to constitute a general business practice, to a civil penalty of not more than \$100,000.

“(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil or monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

“DEFINITIONS

“SEC. 1188. As used in this part:

“(1) AGENT.—The term ‘agent’ means a person, including a contractor, who represents and acts for another under the contract or relation of agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principal and a third person.

“(2) CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.—The term ‘condition-specific limitations on disclosure’ means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

“(3) DISCLOSE.—The term ‘disclose’ means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

“(4) EDUCATIONAL INSTITUTION.—The term ‘educational institution’ means an institution or place accredited or licensed for purposes of providing for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

“(5) EMPLOYER.—The term ‘employer’ has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

“(6) HEALTH CARE.—The term ‘health care’ means—

“(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

“(i) with respect to the physical or mental condition of an individual; or

“(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

“(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

“(7) HEALTH CARE OPERATIONS.—The term ‘health care operations’ means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

“(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

“(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

“(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating.

“(D) Conducting or arranging for auditing services.

“(8) HEALTH CARE PROVIDER.—The term ‘health care provider’ means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

“(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

“(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

“(C) an officer or employee of a person described in subparagraph (A) or (B).

“(9) HEALTH OR LIFE INSURER.—The term ‘health or life insurer’ means a health insurance issuer, as defined in section 9832(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

“(10) HEALTH PLAN.—The term ‘health plan’ means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

“(11) HEALTH RESEARCHER.—The term ‘health researcher’ means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

“(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term ‘nonidentifiable health information’ means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

“(13) ORIGINATING PROVIDER.—The term ‘originating provider’, when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

“(14) PAYMENT ACTIVITIES.—The term ‘payment activities’ means—

“(A) activities undertaken—

“(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

“(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

“(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

“(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

“(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

“(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

“(15) PERSON.—The term ‘person’ means—

“(A) a natural person;

“(B) a government or governmental subdivision, agency, or authority;

“(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

“(D) any other legal entity.

“(16) PROTECTED HEALTH INFORMATION.—The term ‘protected health information’, when used with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

“(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

“(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

“(C) is derived from—

“(i) the provision of health care to an individual; or

“(ii) payment for the provision of health care to an individual; and

“(D) is not nonidentifiable health information.

“(17) STATE.—The term ‘State’ includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

“(18) TREATMENT.—The term ‘treatment’ means the provision of health care by a health care provider.

“(19) WRITING.—The term ‘writing’ means writing either in a paper-based, computer-based, or electronic form, including electronic signatures.”.

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

“(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.”.

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w-22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking “procedures—” and inserting “procedures, consistent with sections 1181 through 1185—”; and

(B) in paragraph (1), by striking “privacy of any individually identifiable enrollee information;” and inserting “confidentiality of

protected health information concerning enrollees;”.

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting “; and”; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

“(T) to comply with sections 1181 through 1184.”.

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

“(E) The confidentiality and accuracy procedure requirements under section 1852(h).”.

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

“TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION”.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking “part C” and inserting “parts C and D”;

(B) in subparagraph (C), by striking “and” at the end;

(C) in subparagraph (D), by striking the period at the end and inserting “; and”; and

(D) by adding at the end the following:

“(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of 1998, shall report to the Congress on such section.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) MODIFICATION OF DEADLINE.—Section 264(c)(1) of the Health Insurance Portability

and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033) is amended by striking “36 months after the date of the enactment of this Act,” and inserting “6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998.”.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) The term “accrediting body” means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term “health care provider” has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term “health care response information” means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider’s notification to an accrediting body and the provider’s plans of action in response to such event).

(5) The term “State” has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

SEC. 6001. MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES.

(a) MEDICAL SAVINGS ACCOUNTS.—

(1) CONTRIBUTIONS.—Title 5, United States Code, is amended by redesignating section 8906a as section 8906c and by inserting after section 8906 the following:

“§8906a. Government contributions to medical savings accounts

“(a) An employee or annuitant enrolled in a high deductible health plan is entitled, in addition to the Government contribution under section 8906(b) toward the subscription charge for such plan, to have a Government contribution made, in accordance with succeeding provisions of this section, to a medical savings account of such employee or annuitant.

“(b)(1) The biweekly Government contribution under this section shall, in the case of any such employee or annuitant, be equal to the amount by which—

“(A) the biweekly equivalent of the maximum Government contribution for the contract year involved (as defined by paragraph (2)), exceeds (if at all)

“(B) the amount of the biweekly Government contribution payable on such employee's or annuitant's behalf under section 8906(b) for the period involved.

“(2) For purposes of this section, the term ‘maximum Government contribution’ means, with respect to a contract year, the maximum Government contribution that could be made for health benefits for an employee or annuitant for such contract year, as determined under section 8906(b) (disregarding paragraph (2) thereof).

“(3) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee or annuitant for any period—

“(A) if, as of the first day of the month before the month in which such period commences, such employee or annuitant (or the spouse of such employee or annuitant, if coverage is for self and family) is entitled to benefits under part A of title XVIII of the Social Security Act;

“(B) to the extent that such contribution, when added to previous contributions made under this section for that same year with respect to such employee or annuitant, would cause the total to exceed—

“(i) the highest annual limit deductible permitted under clause (i) or (ii) of section 220(c)(2)(A) of the Internal Revenue Code of 1986, as appropriate (determined taking into account any changes in coverage that may occur), for the calendar year in which such period commences; or

“(ii) such lower amount (relative to the limitation that would otherwise apply under clause (i)) as the employee or annuitant may specify in accordance with regulations of the Office, including an election not to receive contributions under this section for a year or the remainder of a year; or

“(C) for which any information (or documentation) under subsection (d) that is needed in order to make such contribution has not been timely submitted.

“(4) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee for any period in a contract year unless that employee was enrolled in a health benefits plan under this chapter as an employee for not less than—

“(A) the 1 year of service immediately before the start of such contract year, or

“(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the day before the start of such contract year, whichever is shorter.

“(5) The Office shall provide for the conversion of biweekly rates of contributions specified by paragraph (1) to rates for employees and annuitants whose pay or annuity is provided on other than a biweekly basis,

and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

“(C) A Government contribution under this section—

“(1) shall be made at the same time that, and the same frequency with which, Government contributions under section 8906(b) are made for the benefit of the employee or annuitant involved; and

“(2) shall be payable from the same appropriation, fund, account, or other source as would any Government contributions under section 8906(b) with respect to the employee or annuitant involved.

“(d) The Office shall by regulation prescribe the time, form, and manner in which an employee or annuitant shall submit any information (and supporting documentation) necessary to identify any medical savings account to which contributions under this section are requested to be made.

“(e) Nothing in this section shall be considered to entitle an employee or annuitant to any Government contribution under this section with respect to any period for which such employee or annuitant is ineligible for a Government contribution under section 8906(b).

“§8906b. Individual contributions to medical savings accounts

“(a) Upon the written request of an employee or annuitant enrolled in a high deductible health plan, there shall be withheld from the pay or annuity of such employee or annuitant and contributed to the medical savings account identified by such employee or annuitant in accordance with applicable regulations under subsection (c) such amount as the employee or annuitant may specify.

“(b) Notwithstanding subsection (a), no withholding under this section may be made from the pay or annuity of an employee or annuitant for any period—

“(1) if, or to the extent that, a Government contribution for such period under section 8906a would not be allowable by reason of subparagraph (A) or (B)(i) of subsection (b)(3) thereof;

“(2) for which any information (or documentation) that is needed in order to make such contribution has not been timely submitted; or

“(3) if the employee or annuitant submits a request for termination of withholdings, beginning on or after the effective date of the request and before the end of the year.

“(c) The Office of Personnel Management shall prescribe any regulations necessary to carry out this section, including provisions relating to the time, form, and manner in which any request for withholdings under this section may be made, changed, or terminated.”.

(2) RULES OF CONSTRUCTION.—Nothing in this section or in any amendment made by this section shall be considered—

(A) to permit or require that any contributions to a medical savings account (whether by the Government or through withholdings from pay or annuity) be paid into the Employees Health Benefits Fund; or

(B) to affect any authority under section 1005(f) of title 39, United States Code, to vary, add to, or substitute for any provision of chapter 89 of title 5, United States Code, as amended by this section.

(3) CONFORMING AMENDMENTS.—

(A) The table of sections at the beginning of chapter 89 of title 5, United States Code, is amended by striking the item relating to section 8906a and inserting the following:

“8906a. Government contributions to medical savings accounts.

“8906b. Individual contributions to medical savings accounts.

“8906c. Temporary employees.”.

(B) Section 8913(b)(4) of title 5, United States Code, is amended by striking “8906a(a)” and inserting “8906c(a)”.

(b) INFORMATIONAL REQUIREMENTS.—Section 8907 of title 5, United States Code, is amended by adding at the end the following:

“(c) In addition to any information otherwise required under this section, the Office shall make available to all employees and annuitants eligible to enroll in a high deductible health plan, information relating to—

“(1) the conditions under which Government contributions under section 8906a shall be made to a medical savings account;

“(2) the amount of any Government contributions under section 8906a to which an employee or annuitant may be entitled (or how such amount may be ascertained);

“(3) the conditions under which contributions to a medical savings account may be made under section 8906b through withholdings from pay or annuity; and

“(4) any other matter the Office considers appropriate in connection with medical savings accounts.”.

(c) HIGH DEDUCTIBLE HEALTH PLAN AND MEDICAL SAVINGS ACCOUNT DEFINED.—Section 8901 of title 5, United States Code, is amended—

(1) in paragraph (10) by striking “and” after the semicolon;

(2) in paragraph (11) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

“(12) the term ‘high deductible health plan’ means a plan described by section 8903(5) or section 8903a(d); and

“(13) the term ‘medical savings account’ has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.”.

(d) AUTHORITY TO CONTRACT FOR HIGH DEDUCTIBLE HEALTH PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

“(p)(1) The Office shall contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan and, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offers a health benefits plan under this chapter.

“(2) The Office may contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan, but does not, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offer a health benefits plan under this chapter.”.

(e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH PLANS AND BENEFITS TO BE PROVIDED THEREUNDER.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

“(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A) One or more plans described by paragraph (1), (2), (3), or (4), which—

“(i) are high deductible health plans (as defined by section 220(c)(2) of the Internal Revenue Code of 1986); and

“(ii) provide benefits of the types referred to by section 8904(a)(5).

“(B) Nothing in this section shall be considered—

“(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2); or

“(ii) to require that a high deductible health plan offer two levels of benefits.”.

(2) TYPES OF BENEFITS.—Section 8904(a) of title 5, United States Code, is amended by inserting after paragraph (4) the following:

“(5) HIGH DEDUCTIBLE HEALTH PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.”.

(3) CONFORMING AMENDMENTS.—

(A) Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

“(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).”.

(B) Section 8909(d) of title 5, United States Code, is amended by striking “8903a(d)” and inserting “8903a(e)”.

(4) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding after paragraph (5) (as added by paragraph (1) of this subsection) as a flush left sentence, the following:

“The Office shall prescribe regulations in accordance with which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).”.

SEC. 6002. EFFECTIVE DATE.

The amendments made by this title shall apply with respect to contract years beginning on or after January 1, 2000. The Office of Personnel Management shall take appropriate measures to ensure that coverage under a high deductible health plan under chapter 89 of title 5, United States Code (as amended by this section) shall be available as of the beginning of the first contract year described in the preceding sentence.

The SPEAKER pro tempore. Pursuant to House Resolution 509, the amendments printed in House Report 105-643 are adopted.

The text of H.R. 4250, as amended pursuant to House Resolution 509, is as follows:

H.R. 4250

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—The Act may be cited as the “Patient Protection Act of 1998”.

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

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections.

Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising under Group Health Plans

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Sec. 1301. Short title of subtitle.

Sec. 1302. 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. Special rules for church plans.

“Sec. 813. Definitions and rules of construction.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Effective date.

Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

“TITLE XXVIII—HEALTHMARTS

“Sec. 2801. Definition of HealthMart.

“Sec. 2802. Application of certain laws and requirements.

“Sec. 2803. Administration.

“Sec. 2804. Definitions.

SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Effective date.

Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

Sec. 3203. Sense of the House of Representatives.

Subtitle D—Revenue Offsets

Sec. 3301. Clarification of definition of specified liability loss.

Sec. 3302. Property subject to a liability treated in same manner as assumption of liability.

Sec. 3303. Limitation on required accrual of amounts received for performance of certain personal services.

Sec. 3304. Returns relating to cancellations of indebtedness by organizations lending money.

Sec. 3305. Clarifications and expansion of mathematical error assessment procedures.

Sec. 3306. Inclusion of rotavirus gastroenteritis as a taxable vaccine.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 4011. Statute of limitations.

Sec. 4012. Calculation and payment of damages.

Sec. 4013. Alternative dispute resolution.

Sec. 4014. Reporting on fraud and abuse enforcement activities.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Sec. 5001. Confidentiality of protected health information.

“PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

“Sec. 1181. Inspection and copying of protected health information.

“Sec. 1182. Supplementation of protected health information.

“Sec. 1183. Notice of confidentiality practices.

“Sec. 1184. Establishment of safeguards.

“Sec. 1185. Availability of protected health information for purposes of health care operations.

“Sec. 1186. Relationship to other laws.

“Sec. 1187. Civil penalties.

“Sec. 1188. Definitions.

Sec. 5002. Study and report on effect of State law on health-related research.

Sec. 5003. Study and report on State law on protected health information.

Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

Sec. 5005. Effective date for standards governing unique health identifiers for individuals.

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

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended further by adding at the end the following new section:

“SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

“(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

“(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ‘health care professional’ means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional’s services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

“(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

“(A) the plan or issuer shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

“(B) the plan or issuer shall provide benefits for additional emergency medical serv-

ices following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

“(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

“(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

“(A) provides benefits under the terms of the plan consisting of—

“(i) routine gynecological care (such as preventive women’s health examinations), or

“(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

“(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider,

if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of paragraph (2).

“(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

“(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

“(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

“(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

“(d) PATIENT ACCESS TO PEDIATRIC CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriate-

ness with respect to coverage of pediatric care.

“(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.”.

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new item:

“Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.”.

SEC. 1002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

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

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

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

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers,

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers,

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers,

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers, or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider, or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

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

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

“DISCLOSURE BY GROUP HEALTH PLANS

“SEC. 111. (a) DISCLOSURE REQUIREMENT.—

“(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

“(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

“(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

“(1) COVERED ITEMS AND SERVICES.—

“(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

“(i) types of items and services (including any special disease management program), and

“(ii) types of health care professionals providing such items and services.

“(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

“(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

“(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

“(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

“(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

“(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

“(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

“(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

“(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

“(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan’s requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

“(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

“(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

“(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or con-

ditions benefits for such care subject to any other term or condition of such plan.

“(C) PARTICIPANT’S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

“(1) a participant’s financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

“(2) the circumstances under which, and the extent to which, the participant’s financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

“(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

“(1) descriptions thereof relating specifically to—

“(A) coverage decisions,

“(B) internal review of coverage decisions, and

“(C) any external review of coverage decisions, and

“(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

“(e) INFORMATION AVAILABLE ON REQUEST.—

“(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

“(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications; and

“(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

“(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or

issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

“(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

“(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

“(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

“(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

“(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) includes a recommendation for modification or reversal of an internal review decision under the plan.

“(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such profes-

sional is compensated in connection with the provision of such medical care.

“(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

“(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage, but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

“(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

“(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

“(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

“(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

“(4) by any other reasonable means of timely informing plan participants.

“(h) DEFINITIONS.—For purposes of this section—

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided such term under section 503(b)(6).

“(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided such term under section 733(a)(2).

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

“(4) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided such term under section 733(b)(2).”

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking “section 733(a)(1)” each place it appears and inserting “section 503(b)(6)”; and

(B) by inserting before the period at the end the following: “; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a).”

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

“Sec. 111. Disclosure by group health plans.
“Sec. 112. Repeal and effective date.”

SEC. 1102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

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

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting “(a) IN GENERAL.—” after “SEC. 503.”;

(2) by inserting “(other than a group health plan)” after “employee benefit plan”; and

(3) by adding at the end the following new subsection:

“(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

“(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

“(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the participant,

“(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

“(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named

fiduciary who did not make the initial decision, and

“(D) meet the additional requirements of this subsection.

“(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

“(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

“(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

“(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

“(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

“(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

“(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

“(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

“(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for the decision—

“(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

“(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

“(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

“(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

“(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

“(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

“(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

“(I) does not meet the plan's requirements for medical appropriateness or necessity, or

“(II) would constitute experimental treatment or technology.

“(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

“(i) the lesser of \$100 or 10 percent of the cost of the medical care involved in the decision, or

“(ii) \$25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest \$10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimburse-

ment if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

“(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

“(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

“(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record,

“(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

“(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

“(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

“(E) INDEPENDENT MEDICAL EXPERTS.—

“(i) IN GENERAL.—For purposes of this paragraph, the term ‘independent medical expert’ means, in connection with any coverage decision by a group health plan, a professional—

“(I) who is a physician or, if appropriate, another medical professional,

“(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

“(III) who was not involved in the initial decision or any earlier review thereof, and

“(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

“(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

“(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in

connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert.

“(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

“(III) the expert is selected by an organization described in section 1152(l)(A) of the Social Security Act which meets the requirements of clause (iii),

“(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

“(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (iii).

“(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

“(I) the expert or entity is not affiliated with any related party,

“(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

“(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

“(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

“(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term ‘related party’ means—

“(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

“(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

“(III) the institution at which the medical care involved in the coverage decision is provided,

“(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

“(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

“(v) AFFILIATED.—For purposes of clause (iii)(I), the term ‘affiliated’ means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

“(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

“(i) does not meet the plan's requirements for medical appropriateness or necessity, or

“(ii) would constitute experimental treatment or technology (as defined under the plan).

“(5) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—

“(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

“(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

“(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

“(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

“(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

“(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

“(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

“(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

“(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

“(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations, and

“(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

“(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.—In the case of a request for advance determination of coverage consisting of a re-

quest by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term ‘specialist’ means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

“(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

“(A) IN GENERAL.—The term ‘group health plan’ shall have the meaning provided in section 733(a).

“(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

“(9) OTHER DEFINITIONS.—For purposes of this subsection—

“(A) REQUEST FOR BENEFIT PAYMENTS.—The term ‘request for benefit payments’ means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

“(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term ‘required determination of medical necessity’ means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

“(C) ADVANCE DETERMINATION OF COVERAGE.—The term ‘advance determination of coverage’ means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

“(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term ‘request for advance determination of coverage’ means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

“(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term ‘request for expedited advance determination of coverage’ means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

“(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term ‘request for required determination of medical necessity’ means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

“(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term ‘request for expedited required determination of medical necessity’ means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

“(H) URGENT MEDICAL CARE.—The term ‘urgent medical care’ means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

“(i) the imminent death of the participant or beneficiary, or

“(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

“(I) EMERGENCY MEDICAL CARE.—The term ‘emergency medical care’ means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

“(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

“(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(II) serious impairment to bodily functions, or

“(III) serious dysfunction of any bodily organ or part,

or

“(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

“(J) INITIAL DECISION PERIOD.—The term ‘initial decision period’ means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

“(K) INTERNAL REVIEW PERIOD.—The term ‘internal review period’ means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

“(L) URGENT DECISION PERIOD.—The term ‘urgent decision period’ means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

“(M) EMERGENCY DECISION PERIOD.—The term ‘emergency decision period’ means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

“(N) SPECIALTY DECISION PERIOD.—The term ‘specialty decision period’ means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

“(O) RECONSIDERATION PERIOD.—The term ‘reconsideration period’ means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

“(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

“(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

“(P) FILING COMPLETION DATE.—The term ‘filing completion date’ means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

“(Q) REVIEW FILING DATE.—The term ‘review filing date’ means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in

writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

“(R) MEDICAL CARE.—The term ‘medical care’ has the meaning provided such term by section 733(a)(2).

“(S) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided such term by section 733(b)(1).

“(T) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided such term by section 733(b)(2).

“(U) WRITTEN OR IN WRITING.—

“(i) IN GENERAL.—A request or decision shall be deemed to be ‘written’ or ‘in writing’ if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

“(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.”

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

“(6)(A)(i) In any case in which—

“(I) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

“(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court’s discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

“(ii) Such civil penalty shall be in the amount of up to \$500 a day (or up to \$1,000 a day in case of a bad faith failure) from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed \$250,000.

“(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

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

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

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

“(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of one or more group health plans (as defined in section 503(b)(8)) for—

“(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

“(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

“(ii) Such penalty shall be in an amount not to exceed the lesser of—

“(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

“(II) \$100,000.

“(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.”

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

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking “or” at the end;

(2) in subsection (a)(9), by striking the period and inserting “; or”;

(3) by adding at the end of subsection (a) the following new paragraph:

“(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).”

(4) by adding at the end of subsection (b) the following new paragraph:

“(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.”

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking “under subsection (a)(1)(B) of this section” and inserting “under subsection (a)(1)(A) for relief

under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)"; and

(2) in the last sentence, by striking "of actions under paragraphs (1)(B) and (7) of subsection (a) of this section" and inserting "of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)".

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the "Small Business Affordable Health Coverage Act of 1998".

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

"(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

"(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

"(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

"(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

"(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

"(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

"(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

"(1) such certification—

"(A) is administratively feasible,

"(B) is not adverse to the interests of the individuals covered under the plan, and

"(C) is protective of the rights and benefits of the individuals covered under the plan, and

"(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

"(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

"(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

"(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

"(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

"(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

"(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

"(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

"(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

"(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

"(B) LIMITATION.—

"(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

"(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

"(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

"(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

"(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

"(2) the requirements of section 804(a)(1) shall be deemed met.

"(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

"(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

"(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

"(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

"(C) the requirements of section 804 shall be deemed met.

"(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

"(A) the plan is a multiemployer plan, or

"(B) the plan is in existence on April 1, 1997, and would be described in section

3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

“(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

“(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

“(2) all individuals commencing coverage under the plan after certification under this part must be—

“(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

“(B) the beneficiaries of individuals described in subparagraph (A).

“(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

“(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

“(A) the affiliated member was an affiliated member on the date of certification under this part, or

“(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

“(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

“(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

“(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

“(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer,

“(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

“(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

“(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

“(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

“(B) provides that the sponsor of the plan is to serve as a plan sponsor (referred to in section 3(16)(B)), and

“(C) incorporates the requirements of section 806.

“(2) CONTRIBUTION RATES MUST BE NON-DISCRIMINATORY.—

“(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

“(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

“(i) setting contribution rates based on the claims experience of the plan, or

“(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market, subject to the requirements of section 702(b) relating to contribution rates.

“(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

“(4) MARKETING REQUIREMENTS.—

“(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

“(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term ‘State-licensed insurance agents’ means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

“(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

“(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an

exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

“(1) the benefits under the plan consist solely of health insurance coverage, or

“(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

“(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

“(i) a reserve sufficient for unearned contributions,

“(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

“(iii) a reserve sufficient for any other obligations of the plan, and

“(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan, and

“(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

“(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan’s qualified actuary (but not more than \$200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

“(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to \$2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than \$500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

“(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements

relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

“(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

“(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

“(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

“(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

“(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of \$5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

“(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

“(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

“(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Sec-

retary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

“(3) ASSOCIATION HEALTH PLAN FUND.—

“(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

“(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

“(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

“(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term ‘aggregate excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

“(B) which is guaranteed renewable, and

“(C) which allows for payment of premiums by any third party on behalf of the insured plan.

“(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term ‘specific excess/stop loss insurance’ means, in connection with an association health plan, a contract—

“(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual,

“(B) which is guaranteed renewable, and

“(C) which allows for payment of premiums by any third party on behalf of the insured plan.

“(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term ‘indemnification insurance’ means, in connection with an association health plan, a contract—

“(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

“(2) which is guaranteed renewable and noncancellable for any reason (except as may be provided in regulations of the applicable authority), and

“(3) which allows for payment of premiums by any third party on behalf of the insured plan.

“(i) RESERVES.—For purposes of this section, the term ‘reserves’ means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as may be pre-

scribed in regulations of the applicable authority.

“(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

“(1) a representative of the National Association of Insurance Commissioners,

“(2) a representative of the American Academy of Actuaries,

“(3) a representative of the State governments, or their interests,

“(4) a representative of existing self-insured arrangements, or their interests,

“(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

“(6) a representative of multiemployer plans that are group health plans, or their interests.

“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

“(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of \$5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

“(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

“(1) IDENTIFYING INFORMATION.—The names and addresses of—

“(A) the sponsor, and

“(B) the members of the board of trustees of the plan.

“(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

“(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

“(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any by-laws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

“(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

“(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

“(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

“(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

“(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

“(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

“(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

“(C) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

“(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

“(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

“(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this

part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

“(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

“(2) represent such actuary's best estimate of anticipated experience under the plan. The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

“Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

“(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

“(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

“(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

“(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

“(b) MANDATORY TERMINATION.—In any case in which—

“(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

“(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

“(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

“(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

“(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

“(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

“(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

“(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

“(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

“(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

“(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

“(8) to terminate the plan (or provide for its termination) in accordance with section 809(b) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship,

“(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

“(10) to do such other acts as may be necessary to comply with this title or any order

of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

“(C) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary’s appointment as trustee, the Secretary shall give notice of such appointment to—

“(1) the sponsor and plan administrator,

“(2) each participant,

“(3) each participating employer, and

“(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

“(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

“(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

“(f) JURISDICTION OF COURT.—

“(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

“(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

“(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary’s service as trustee under this section.

“SEC. 811. STATE ASSESSMENT AUTHORITY.

“(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

“(b) CONTRIBUTION TAX.—For purposes of this section, the term ‘contribution tax’ imposed by a State on an association health plan means any tax imposed by such State if—

“(1) such tax is computed by applying a rate to the amount of premiums or contribu-

tions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

“(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

“(3) such tax is otherwise nondiscriminatory, and

“(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

“(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

“(b) EFFECT OF ELECTION.—

“(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

“(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

“(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

“(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

“(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

“(4) DEFINITIONS.—For purposes of this subsection—

“(A) STATE LAW.—The term ‘State law’ includes all laws, decisions, rules, regulations,

or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

“(B) STATE.—The term ‘State’ includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

“(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

“(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

“(A) for the exclusive purpose of:

“(i) providing benefits to participants and their beneficiaries; and

“(ii) defraying reasonable expenses of administering the plan;

“(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

“(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

“(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

“(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

“(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

“(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

“(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

“(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

“(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

“(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

“(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

“(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

“(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan’s failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

“(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

“(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

“(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

“(a) DEFINITIONS.—For purposes of this part—

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

“(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided in section 733(a)(2).

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

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

“(5) APPLICABLE AUTHORITY.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘applicable authority’ means, in connection with an association health plan—

“(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

“(ii) if there is no State referred to in clause (i), the Secretary.

“(B) EXCEPTIONS.—

“(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

“(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

“(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

“(7) INDIVIDUAL MARKET.—

“(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

“(B) TREATMENT OF VERY SMALL GROUPS.—

“(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

“(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

“(8) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

“(9) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

“(10) QUALIFIED ACTUARY.—The term ‘qualified actuary’ means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

“(11) AFFILIATED MEMBER.—The term ‘affiliated member’ means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

“(12) LARGE EMPLOYER.—The term ‘large employer’ means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

“(13) SMALL EMPLOYER.—The term ‘small employer’ means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

“(b) RULES OF CONSTRUCTION.—

“(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

“(A) in the case of a partnership, the term ‘employer’ (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term ‘employee’ (as defined in section (3)(6)) includes any partner in relation to the partnership, and

“(B) in the case of a self-employed individual, the term ‘employer’ (as defined in sec-

tion 3(5)) and the term ‘employee’ (as defined in section 3(6)) shall include such individual.

“(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.”

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

“(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.”

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (d)”;

(B) in subsection (b)(5), by striking “subsection (a)” in subparagraph (A) and inserting “subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

“(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

“(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

“(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

“(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

“(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

“(4) For purposes of this subsection, the term ‘association health plan’ has the meaning provided in section 801(a), and the terms

'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively."

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking "and" at the end;

(B) in clause (ii), by inserting "and which does not provide medical care (within the meaning of section 733(a)(2))," after "arrangement," and by striking "title," and inserting "title, and"; and

(C) by adding at the end the following new clause:

"(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply."

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking "Nothing" and inserting "(1) Except as provided in paragraph (2), nothing"; and

(B) by adding at the end the following new paragraph:

"(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section."

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes a person serving as the sponsor of an association health plan under part 8."

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: "An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any."

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting "or part 8" after "this part".

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"Sec. 801. Association health plans.

"Sec. 802. Certification of association health plans.

"Sec. 803. Requirements relating to sponsors and boards of trustees.

"Sec. 804. Participation and coverage requirements.

"Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

"Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

"Sec. 807. Requirements for application and related requirements.

"Sec. 808. Notice requirements for voluntary termination.

"Sec. 809. Corrective actions and mandatory termination.

"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

"Sec. 811. State assessment authority.

"Sec. 812. Special rules for church plans.

"Sec. 813. Definitions and rules of construction."

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement;" after "single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "control group";

(2) in clause (iii)—

(A) by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 percent may not be required as the minimum interest necessary for common control"; and

(B) by striking "similar to" and inserting "consistent and coextensive with";

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement."

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

"(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E)";

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

"(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

"(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

"(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount

of size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

"(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

"(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

"(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

"(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

"(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

"(ii)(I) the plan or arrangement is a multi-employer plan; and

"(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

"(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

"(ii) the employee organization or other entity sponsoring the plan or arrangement—

"(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

"(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement."

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: "Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii)."

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "SEC. 501."; and

(2) by adding at the end the following new subsection:

"(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

"(1) being an association health plan which has been certified under part 8;

"(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

"(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met; shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both."

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

"(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

"(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

"(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

"(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

"(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

"(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan."

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C.

1133) (as amended by title I) is amended by adding at the end the following new subsection:

"(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan."

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

"(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

"(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

"(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

"(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

"(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

"(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained."

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least

10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms "group health plan," "medical care," and "participating employer" shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "association health plan" shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term “pilot program period” means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

“SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

“(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

“(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ‘health care professional’ means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional’s services is provided under the group health plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

“(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

“(A) the plan or issuer shall provide benefits, and without regard to otherwise applicable network limitations, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent

layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

“(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

“(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

“(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

“(A) provides benefits under the terms of the plan consisting of—

“(i) routine gynecological care (such as preventive women’s health examinations), or

“(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

“(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan (or issuer) shall meet the requirements of paragraph (2).

“(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

“(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

“(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

“(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

“(d) PATIENT ACCESS TO PEDIATRIC CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or bene-

ficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

“(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.”.

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

“SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

“(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

“(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

“(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a

coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

“(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

“(c) EXCEPTIONS.—

“(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

“(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

“(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

“(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

“(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently than once every two years.

“(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently than once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

“(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

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

“(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

“(2) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ has the meaning given such term in section 2706(a)(2).”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A of this title) is amended further by adding at the end the following new section:

“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

“(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

“(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

“(1) COVERED ITEMS AND SERVICES.—

“(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

“(i) types of items and services (including any special disease management program), and

“(ii) types of health care professionals providing such items and services.

“(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

“(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

“(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug

formulary and a summary of the process for determining what is included in such formulary.

“(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

“(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

“(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

“(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

“(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

“(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

“(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

“(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

“(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

“(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

“(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

“(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

“(C) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

“(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

“(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

“(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

“(1) descriptions thereof relating specifically to—

“(A) coverage decisions,

“(B) internal review of coverage decisions, and

“(C) any external review of coverage decisions, and

“(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

“(e) INFORMATION AVAILABLE ON REQUEST.—

“(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

“(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications, and

“(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

“(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

“(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

“(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a

specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

“(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

“(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

“(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) of such Act includes a recommendation for modification or reversal of an internal review decision under the plan.

“(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

“(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

“(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE

PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant and an employee who, under the terms of the plan, is eligible for coverage but not enrolled in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

“(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

“(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

“(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

“(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

“(4) by any other reasonable means of timely informing plan participants.”

SEC. 2102. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the “Health Care Consumer Empowerment Act of 1998”.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

“TITLE XXVIII—HEALTHMARTS

“SEC. 2801. DEFINITION OF HEALTHMART.

“(a) IN GENERAL.—For purposes of this title, the term ‘HealthMart’ means a legal entity that meets the following requirements:

“(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

“(A) Small employers.

“(B) Employees of small employers.

“(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

“(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

“(2) OFFERING HEALTH BENEFITS COVERAGE.—

“(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

“(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

“(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

“(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

“(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

“(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

“(3) GEOGRAPHIC AREAS.—

“(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

“(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

“(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

“(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

“(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

“(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

“(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination

of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

“(6) FILING INFORMATION.—The HealthMart—

“(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

“(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

“(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

“(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

“(A) be underwritten by a health insurance issuer that—

“(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a)),

“(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

“(iii) offers the coverage under a contract with the HealthMart;

“(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

“(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

“(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

“(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

“(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

“(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

“(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

“(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

“(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

“(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

“(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

“(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

“(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

“(A) Coverage through a health maintenance organization.

“(B) Coverage in connection with a preferred provider organization.

“(C) Coverage in connection with a licensed provider-sponsored organization.

“(D) Indemnity coverage through an insurance company.

“(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

“(F) Coverage that includes a point-of-service option.

“(G) Coverage offered by a community health organization (as defined in section 330B(e)).

“(H) Any combination of such types of coverage.

“(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

“(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

“(1) PURCHASERS.—

“(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

“(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

“(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

“(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

“(2) MEMBERS.—

“(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

“(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

“(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

“(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

“(3) HEALTH INSURANCE ISSUERS.—

“(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

“(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

“(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health

insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

“(d) PREVENTION OF CONFLICTS OF INTEREST.—

“(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

“(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

“(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

“(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

“(B) CONSTRUCTION.—For purposes of subparagraph (A), the term “affiliated” does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

“(e) CONSTRUCTION.—

“(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

“(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

“(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

“(i) a change of employers through which the coverage is provided, or

“(ii) a change in place of employment to an area not served by the previous HealthMart.

“(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

“(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

“(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

“(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

“(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

“(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

“(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

“(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

“(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

“(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

“(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

“(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

“(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

“(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

“(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

“(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of

applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

“(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

“(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

“(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

“SEC. 2803. ADMINISTRATION.

“(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of ‘deemed file and use’ with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

“(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

“(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

“(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

“(A) oversight of the operations of HealthMarts under this title; and

“(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

“(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

“SEC. 2804. DEFINITIONS.

“For purposes of this title:

“(1) APPLICABLE FEDERAL AUTHORITY.—The term ‘applicable Federal authority’ means the Secretary of Health and Human Services.

“(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term ‘eligible’ means, with respect to an

employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

“(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms ‘employer’, ‘employee’, and ‘dependent’, as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

“(4) HEALTH BENEFITS COVERAGE.—The term ‘health benefits coverage’ has the meaning given the term group health insurance coverage in section 2791(b)(4).

“(5) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

“(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning given such term in section 2791(d)(9).

“(7) HEALTHMART.—The term ‘HealthMart’ is defined in section 2801(a).

“(8) MEMBER.—The term ‘member’ means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

“(9) PURCHASER.—The term ‘purchaser’ means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

“(10) SMALL EMPLOYER.—The term ‘small employer’ has the meaning given such term for purposes of title XXVII.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2000. The Secretary of Health and Human Services shall first issue all regulations necessary to carry out such amendment before such date.

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

“WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

“SEC. 330B. (a) WAIVER AUTHORIZED.—

“(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

“(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) by not later than November 1, 2003, and

“(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

“(2) GROUNDS FOR APPROVAL OF WAIVER.—

“(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days

of the date of the State’s receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

“(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

“(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization’s failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

“(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

“(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

“(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

“(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization’s compliance with the requirements described in paragraph (5).

“(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

“(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

“(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization’s compliance with all consumer protection and quality standards insofar as such standards—

“(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

“(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

“(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the

Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

“(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

“(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

“(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

“(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

“(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

“(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

“(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

“(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

“(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

“(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

“(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

“(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

“(B) alternative means of protecting against insolvency, including reinsurance,

unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

“(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

“(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

“(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

“(e) DEFINITIONS.—In this section:

“(1) COMMUNITY HEALTH ORGANIZATION.—The term ‘community health organization’ means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

“(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term ‘Federally-qualified health center’ has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

“(3) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning given such term in section 2791(b)(1).

“(4) CONTROL.—The term ‘control’ means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.”

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNCOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

“SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNCOLOGICAL CARE, PEDIATRIC CARE.

“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

“(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan, the plan with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan.

“(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ‘health care professional’ means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the group health plan for the

services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(b) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

“(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

“(A) the plan shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary in order to determine whether emergency medical care (as so defined) is required, and

“(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

“(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

“(c) PATIENT ACCESS TO OBSTETRIC AND GYNCOLOGICAL CARE.

“(1) IN GENERAL.—In any case in which a group health plan—

“(A) provides benefits under the terms of the plan consisting of—

“(i) routine gynecological care (such as preventive women's health examinations), or

“(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

“(B) the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, if the primary care provider designated by such a participant or beneficiary is not such a physician, then the plan shall meet the requirements of paragraph (2).

“(2) REQUIREMENTS.—A group health plan meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan—

“(A) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

“(B) treats the ordering of other routine care of the same type, by the participating physician providing the care described in clause (i) or (ii) of paragraph (1)(A), as the authorization of the primary care provider with respect to such care.

“(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

“(d) PATIENT ACCESS TO PEDIATRIC CARE.—

“(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

“(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.”

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

“Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.”

SEC. 3002. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs before the date of issuance of regulations issued in connection with such requirement if the plan has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard

to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

“SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

“(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance coverage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

“(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

“(1) COVERED ITEMS AND SERVICES.—

“(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

“(i) types of items and services (including any special disease management program), and

“(ii) types of health care professionals providing such items and services.

“(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

“(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

“(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

“(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

“(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

“(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

“(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

“(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to

which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

“(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

“(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

“(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

“(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

“(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

“(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan

“(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

“(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

“(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

“(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

“(1) descriptions thereof relating specifically to—

“(A) coverage decisions,

“(B) internal review of coverage decisions, and

“(C) any external review of coverage decisions, and

“(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

“(e) INFORMATION AVAILABLE ON REQUEST.—

“(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

“(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to

participants and beneficiaries, in a generally recognized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications; and

“(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

“(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

“(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

“(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

“(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

“(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

“(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licensing status (if any) of each health insur-

ance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

“(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

“(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) of such Act includes a recommendation for modification or reversal of an internal review decision under the plan.

“(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

“(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

“(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

“(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

“(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

“(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

“(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

“(4) by any other reasonable means of timely informing plan participants.”.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

“Sec. 9814. Disclosure by group health plans.”

SEC. 3102. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of the Treasury or the Secretary's delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking “and such employer is a small employer”.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to ½ of the annual deductible (as of the first day of such month) of the taxpayer's coverage under the high deductible health plan.”

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking “75 percent of”.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

“(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply

under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year."

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking "\$1,500" and inserting "\$1,000", and

(B) by striking "\$3,000" and inserting "\$2,000".

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking "1998" and inserting "1999", and

(B) by striking "1997" and inserting "1998".

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking "106(b)."

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

"(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

"(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

"(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

"(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I)."

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

"(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

"(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined in section 330(b)(1)(A) of such Act) provided on a capitated basis.

"(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year."

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking "and" at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting "; and", and

(3) by inserting after subparagraph (L) the following new subparagraph:

"(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be required by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section."

SEC. 3203. SENSE OF THE HOUSE OF REPRESENTATIVES.

It is the sense of the House of Representatives that patients are best served when they are empowered to make informed choices about their own health care. The same is true regarding an individual's choice of health insurance. A system that gives people the power to choose the coverage that best meets their needs, combined with insurance market reforms, offers great promise of increased choices and greater access to health insurance for Americans.

Subtitle D—Revenue Offsets

SEC. 3301. CLARIFICATION OF DEFINITION OF SPECIFIED LIABILITY LOSS.

(a) IN GENERAL.—Subparagraph (B) of section 172(f)(1) of the Internal Revenue Code of 1986 (defining specified liability loss) is amended to read as follows:

"(B)(i) Any amount allowable as a deduction under this chapter (other than section 468(a)(1) or 468A(a)) which is in satisfaction of a liability under a Federal or State law requiring—

"(I) the reclamation of land,

"(II) the decommissioning of a nuclear power plant (or any unit thereof),

"(III) the dismantlement of a drilling platform,

"(IV) the remediation of environmental contamination, or

"(V) a payment under any workers compensation act (within the meaning of section 461(h)(2)(C)(i)).

"(ii) A liability shall be taken into account under this subparagraph only if—

"(I) the act (or failure to act) giving rise to such liability occurs at least 3 years before the beginning of the taxable year, and

"(II) the taxpayer used an accrual method of accounting throughout the period or periods during which such act (or failure to act) occurred."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to net operating losses arising in taxable years ending after the date of the enactment of this Act.

SEC. 3302. PROPERTY SUBJECT TO A LIABILITY TREATED IN SAME MANNER AS ASSUMPTION OF LIABILITY.

(a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY TEST.—

(1) SECTION 357.—Section 357(a) of the Internal Revenue Code of 1986 (relating to assumption of liability) is amended by striking "or acquires from the taxpayer property subject to a liability" in paragraph (2).

(2) SECTION 358.—Section 358(d)(1) of such Code (relating to assumption of liability) is amended by striking "or acquired from the taxpayer property subject to a liability".

(3) SECTION 368.—

(A) Section 368(a)(1)(C) of such Code is amended by striking "or the fact that property acquired is subject to a liability".

(B) The last sentence of section 368(a)(2)(B) of such Code is amended by striking "and the amount of any liability to which any property acquired from the acquiring corporation is subject."

(b) CLARIFICATION OF ASSUMPTION OF LIABILITY.—

(1) IN GENERAL.—Section 357 of such Code is amended by adding at the end the following new subsections:

"(d) DETERMINATION OF AMOUNT OF LIABILITY ASSUMED.—

"(1) IN GENERAL.—For purposes of this section, section 358(d), section 362(d), section 368(a)(1)(C), and section 368(a)(2)(B), except as provided in regulations—

"(A) a recourse liability (or portion thereof) shall be treated as having been assumed if, as determined on the basis of all facts and circumstances, the transferee has agreed to, and is expected to, satisfy such liability (or portion), whether or not the transferor has been relieved of such liability, and

"(B) a nonrecourse liability shall be treated as having been assumed by the transferee of any asset subject to such liability.

"(2) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection and section 362(d). The Secretary may also prescribe regulations which provide that the manner in which a liability is treated as assumed under this subsection is applied, where appropriate, elsewhere in this title."

(2) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—Section 362 of such Code is amended by adding at the end the following new subsection:

"(d) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—

"(1) IN GENERAL.—In no event shall the basis of any property be increased under subsection (a) or (b) above fair market value (determined without regard to section 7701(g)) by reason of any gain recognized to the transferor as a result of the assumption of a liability.

"(2) TREATMENT OF GAIN NOT SUBJECT TO TAX.—Except as provided in regulations, if—

"(A) gain is recognized to the transferor as a result of an assumption of a nonrecourse liability by a transferee which is also secured by assets not transferred to such transferee, and

"(B) no person is subject to tax under this title on such gain,

then, for purposes of determining basis under subsections (a) and (b), the amount of gain recognized by the transferor as a result of the assumption of the liability shall be determined as if the liability assumed by the transferee equaled such transferee's ratable portion of such liability determined on the basis of the relative fair market values (determined without regard to section 7701(g)) of all of the assets subject to such liability."

(c) APPLICATION TO PROVISIONS OTHER THAN SUBCHAPTER C.—

(1) SECTION 584.—Section 584(h)(3) of such Code is amended—

(A) by striking "and the fact that any property transferred by the common trust fund is subject to a liability," in subparagraph (A),

(B) by striking clause (ii) of subparagraph (B) and inserting:

"(ii) ASSUMED LIABILITIES.—For purposes of clause (i), the term 'assumed liabilities' means any liability of the common trust fund assumed by any regulated investment company in connection with the transfer referred to in paragraph (1)(A).

"(C) ASSUMPTION.—For purposes of this paragraph, in determining the amount of any liability assumed, the rules of section 357(d) shall apply."

(2) SECTION 1031.—The last sentence of section 1031(d) of such Code is amended—

(A) by striking "assumed a liability of the taxpayer or acquired from the taxpayer property subject to a liability" and inserting "assumed (as determined under section 357(d)) a liability of the taxpayer", and

(B) by striking "or acquisition (in the amount of the liability)".

(d) CONFORMING AMENDMENTS.—

(1) Section 351(h)(1) of such Code is amended by striking ", or acquires property subject to a liability,".

(2) Section 357 of such Code is amended by striking "or acquisition" each place it appears in subsection (a) or (b).

(3) Section 357(b)(1) of such Code is amended by striking "or acquired".

(4) Section 357(c)(1) of such Code is amended by striking ", plus the amount of the liabilities to which the property is subject,".

(5) Section 357(c)(3) of such Code is amended by striking "or to which the property transferred is subject".

(6) Section 358(d)(1) of such Code is amended by striking "or acquisition (in the amount of the liability)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers after the date of the enactment of this Act.

SEC. 3303. LIMITATION ON REQUIRED ACCRUAL OF AMOUNTS RECEIVED FOR PERFORMANCE OF CERTAIN PERSONAL SERVICES.

(a) IN GENERAL.—Paragraph (5) of section 448(d) of the Internal Revenue Code of 1986 (relating to special rule for services) is amended by inserting "in fields referred to in paragraph (2)(A)" after "services by such person".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1998.

(c) COORDINATION WITH SECTION 481.—In the case of any taxpayer required by this section to change its method of accounting for any taxable year—

(1) such change shall be treated as initiated by the taxpayer,

(2) such change shall be treated as made with the consent of the Secretary of the Treasury, and

(3) the period for taking into account the adjustments under section 481 by reason of such change shall be 3 years.

SEC. 3304. RETURNS RELATING TO CANCELLATIONS OF INDEBTEDNESS BY ORGANIZATIONS LENDING MONEY.

(a) IN GENERAL.—Paragraph (2) of section 6050P(c) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by inserting after subparagraph (C) the following new subparagraph:

"(D) any organization a significant trade or business of which is the lending of money."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness after December 31, 1998.

SEC. 3305. CLARIFICATION AND EXPANSION OF MATHEMATICAL ERROR ASSESSMENT PROCEDURES.

(a) TIN DEEMED INCORRECT IF INFORMATION ON RETURN DIFFERS WITH AGENCY RECORDS.—Section 6213(g)(2) of the Internal Revenue Code of 1986 (defining mathematical or clerical error) is amended by adding at the end the following flush sentence:

"A taxpayer shall be treated as having omitted a correct TIN for purposes of the preceding sentence if information provided by the taxpayer on the return with respect to the individual whose TIN was provided differs from the information the Secretary obtains from the person issuing the TIN."

(b) EXPANSION OF MATHEMATICAL ERROR PROCEDURES TO CASES WHERE TIN ESTAB-

LISHES INDIVIDUAL NOT ELIGIBLE FOR TAX CREDIT.—Section 6213(g)(2) of such Code is amended by striking "and" at the end of subparagraph (J), by striking the period at the end of the subparagraph (K) and inserting ", and", and by adding at the end the following new subparagraph:

"(L) the inclusion on a return of a TIN required to be included on the return under section 21, 24, or 32 if—

"(i) such TIN is of an individual whose age affects the amount of the credit under such section, and

"(ii) the computation of the credit on the return reflects the treatment of such individual as being of an age different from the individual's age based on such TIN."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3306. INCLUSION OF ROTAVIRUS GASTROENTERITIS AS A TAXABLE VACCINE.

(a) IN GENERAL.—Section 4132(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

"(K) Any vaccine against rotavirus gastroenteritis."

(b) EFFECTIVE DATE.—

(1) SALES.—The amendment made by this section shall apply to sales after the date of the enactment of this Act.

(2) DELIVERIES.—For purposes of paragraph (1), in the case of sales on or before the date of the enactment of this Act for which delivery is made after such date, the delivery date shall be considered the sale date.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic

damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of \$50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term "actual damages" means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term "claimant" means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term "clear and convincing evidence" is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term "collateral source payments" means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term "drug" has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term "economic loss" means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term "harm" means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term "health benefit plan" means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) **HEALTH CARE LIABILITY ACTION.**—The term “health care liability action” means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) **HEALTH CARE LIABILITY CLAIM.**—The term “health care liability claim” means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) **HEALTH CARE PROVIDER.**—The term “health care provider” means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) **HEALTH CARE SERVICE.**—The term “health care service” means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) **MEDICAL DEVICE.**—The term “medical device” has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) **NON-ECONOMIC DAMAGES.**—The term “non-economic damages” means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) **PERSON.**—The term “person” means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) **PRODUCT SELLER.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), the term “product seller” means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) **EXCLUSION.**—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) **PUNITIVE DAMAGES.**—The term “punitive damages” means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) **STATE.**—The term “State” means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) **LIMITATION ON NON-ECONOMIC DAMAGES.**—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed \$250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) **LIMIT.**—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) **JOINT AND SEVERAL LIABILITY.**—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) **GENERAL RULE.**—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) **APPLICABILITY.**—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) **BIFURCATION.**—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) **IN GENERAL.—**

(i) **PUNITIVE DAMAGES.**—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) **APPLICATION.**—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) **PACKAGING.**—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) **GENERAL RULE.**—In any health care liability action in which the damages awarded

for future economic and non-economic loss exceeds \$50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

SEC. 4014. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys with the guideline entitled "Guidance on the Use of the False Claims Act in Civil Health Care Matters" issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled "National Project Protocols—Best Practice Guidelines" issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce, the Committee on the Judiciary, and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

"PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

"INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

"SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

"(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

"(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v-1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

"(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

"(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

"(2) the information is compiled principally—

"(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

"(B) for use in such action or proceeding.

"(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

"(1) the reasons for the denial of the request;

"(2) the availability of procedures for further review of the denial; and

"(3) the individual's right to file with the person a concise statement setting forth the request.

"(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

"(1) shall include a notation concerning the individual's statement; and

"(2) may include a concise statement of the reasons for denying the request for inspection or copying.

"(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section may

set forth appropriate procedures to be followed for such inspection or copying and may require an individual to pay reasonable costs associated with such inspection or copying.

"(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

"(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

"(j) RULES GOVERNING AGENTS.—An agent of a person described in subsection (a) shall not be required to provide for the inspection and copying of protected health information, except where—

"(1) the protected health information is retained by the agent; and

"(2) the agent has been asked by the person to fulfill the requirements of this section.

"SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

"SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

"(1) shall make the amendment requested;

"(2) shall inform the individual of the amendment that has been made; and

"(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

"(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested by an individual under such subsection, the person shall inform the individual, in writing, of—

"(1) the reasons for the refusal to make the amendment;

"(2) any procedures for further review of the refusal; and

"(3) the individual's right to file with the person a concise statement setting forth the requested amendment and the individual's reasons for disagreeing with the refusal.

"(c) STATEMENT OF DISAGREEMENT.—If an individual has filed a statement of disagreement with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

"(1) shall include a notation that such individual has filed a statement of disagreement; and

"(2) may include a concise statement of the reasons for not making the requested amendment.

"(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

"(1) the information is retained by the agent; and

"(2) the agent has been asked by such person to fulfill the requirements of this section.

“(e) **DUPLICATIVE REQUESTS FOR AMENDMENTS.**—If a person described in subsection (a) receives a duplicative request for an amendment of information as provided for in such subsection and a statement of disagreement with respect to the request has been filed pursuant to subsection (c), the person shall inform the individual of such filing and shall not be required to carry out the procedures under this section.

“(f) **RULE OF CONSTRUCTION.**—This section shall not be construed—

“(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

“(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

“**NOTICE OF CONFIDENTIALITY PRACTICES**

“**SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.**—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

“(1) a description of an individual's rights with respect to protected health information;

“(2) the intended uses and disclosures of protected health information;

“(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

“(4) the procedures established by the person for obtaining copies of the notice.

“(b) **MODEL NOTICE.**—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

“**ESTABLISHMENT OF SAFEGUARDS**

“**SEC. 1184. (a) IN GENERAL.**—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by the person.

“(b) **FACTORS TO BE CONSIDERED.**—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

“(1) The need for protected health information.

“(2) The categories of personnel who will have access to protected health information.

“(3) The feasibility of limiting access to individual identifiers.

“(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

“(5) The value of audit trails in computerized records.

“(c) **RELATIONSHIP TO PART C REQUIREMENT.**—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

“(d) **CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.**—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into non-identifiable health information.

“**AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS**

“**SEC. 1185. (a) DISCLOSURE.**—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

“(b) **USE.**—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

“(c) **LIMITATION ON SALE OR BARTER.**—Notwithstanding subsection (b), no health care provider or health plan may, as part of conducting health care operations, sell or barter protected health information.

“**RELATIONSHIP TO OTHER LAWS**

“**SEC. 1186. (a) STATE LAW.**—

“(1) **IN GENERAL.**—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

“(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

“(B) relates to authorization for the use or disclosure of—

“(i) protected health information for health care operations; or

“(ii) nonidentifiable health information; or

“(C) relates to any of the following:

“(i) Inspection or copying of protected health information by a person who is a subject of the information.

“(ii) Amendment of protected health information by a person who is a subject of the information.

“(iii) Notice of confidentiality practices with respect to protected health information.

“(iv) Establishment of safeguards for protected health information.

“(2) **EXCEPTIONS.**—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

“(A) the confidentiality of the records maintained by a licensed mental health professional;

“(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

“(C) condition-specific limitations on disclosure;

“(D) the use or disclosure of information for use in legally authorized—

“(i) disease or injury reporting;

“(ii) public health surveillance, investigation, or intervention;

“(iii) vital statistics reporting, such as reporting of birth or death information;

“(iv) reporting of abuse or neglect information;

“(v) reporting of information concerning a communicable disease status; or

“(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

“(E) the disclosure to a person by a health care provider of information about an indi-

vidual, in any case in which the provider has determined—

“(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

“(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

“(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

“(3) **PRIVILEGES.**—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

“(b) **FEDERAL LAW.**—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

“**CIVIL PENALTIES**

“**SEC. 1187. (a) VIOLATION.**—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any other penalties that may be prescribed by law—

“(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than \$500 for each such violation but not to exceed \$5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

“(2) in a case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than \$10,000 for each such violation, but not to exceed \$50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

“(3) in a case in which the Secretary finds that such violations have occurred with such frequency as to constitute a general business practice, to a civil penalty of not more than \$100,000.

“(b) **PROCEDURES FOR IMPOSITION OF PENALTIES.**—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil or monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

“**DEFINITIONS**

“**SEC. 1188. As used in this part:**

“(1) **AGENT.**—The term ‘agent’ means a person, including a contractor, who represents and acts for another under the contract or relation of agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principal and a third person.

“(2) **CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.**—The term ‘condition-specific limitations on disclosure’ means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

“(3) **DISCLOSE.**—The term ‘disclose’ means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

“(4) EDUCATIONAL INSTITUTION.—The term ‘educational institution’ means an institution or place accredited or licensed for purposes of providing for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

“(5) EMPLOYER.—The term ‘employer’ has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

“(6) HEALTH CARE.—The term ‘health care’ means—

“(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

“(i) with respect to the physical or mental condition of an individual; or

“(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

“(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

“(7) HEALTH CARE OPERATIONS.—The term ‘health care operations’ means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

“(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

“(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

“(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating.

“(D) Conducting or arranging for auditing services.

“(8) HEALTH CARE PROVIDER.—The term ‘health care provider’ means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

“(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

“(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

“(C) an officer or employee of a person described in subparagraph (A) or (B).

“(9) HEALTH OR LIFE INSURER.—The term ‘health or life insurer’ means a health insurance issuer, as defined in section 9832(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

“(10) HEALTH PLAN.—The term ‘health plan’ means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

“(11) HEALTH RESEARCHER.—The term ‘health researcher’ means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

“(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term ‘nonidentifiable health information’ means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

“(13) ORIGINATING PROVIDER.—The term ‘originating provider’, when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

“(14) PAYMENT ACTIVITIES.—The term ‘payment activities’ means—

“(A) activities undertaken—

“(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

“(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

“(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

“(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

“(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

“(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

“(15) PERSON.—The term ‘person’ means—

“(A) a natural person;

“(B) a government or governmental subdivision, agency, or authority;

“(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

“(D) any other legal entity.

“(16) PROTECTED HEALTH INFORMATION.—The term ‘protected health information’, when used with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

“(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

“(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

“(C) is derived from—

“(i) the provision of health care to an individual; or

“(ii) payment for the provision of health care to an individual; and

“(D) is not nonidentifiable health information.

“(17) STATE.—The term ‘State’ includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

“(18) TREATMENT.—The term ‘treatment’ means the provision of health care by a health care provider.

“(19) WRITING.—The term ‘writing’ means writing either in a paper-based, computer-based, or electronic form, including electronic signatures.”

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

“(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.”

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w-22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking “procedures—” and inserting “procedures, consistent with sections 1181 through 1185—”; and

(B) in paragraph (1), by striking “privacy of any individually identifiable enrollee information;” and inserting “confidentiality of protected health information concerning enrollees;”

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting “; and”; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

“(T) to comply with sections 1181 through 1184.”

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

“(E) The confidentiality and accuracy procedure requirements under section 1852(h).”

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

“TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION”.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking “part C” and inserting “parts C and D”;

(B) in subparagraph (C), by striking “and” at the end;

(C) in subparagraph (D), by striking the period at the end and inserting “; and”;

(D) by adding at the end the following:

“(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of

1998, shall report to the Congress on such section.”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) **IN GENERAL.**—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) **MODIFICATION OF DEADLINE.**—Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033) is amended by striking “36 months after the date of the enactment of this Act,” and inserting “6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998.”.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) **PROTECTION OF CERTAIN INFORMATION.**—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

- (1) Peer review.
- (2) Utilization review.
- (3) Quality management or improvement.
- (4) Quality control.
- (5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) **NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.**—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

(c) **DEFINITIONS.**—For purposes of this section:

(1) The term “accrediting body” means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term “health care provider” has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term “health care response information” means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider’s notification to an accrediting body and the provider’s plans of action in response to such event).

(5) The term “State” has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

SEC. 5005. EFFECTIVE DATE FOR STANDARDS GOVERNING UNIQUE HEALTH IDENTIFIERS FOR INDIVIDUALS.

Section 1174 of the Social Security Act (42 U.S.C. 1320d-3) is amended by adding at the end the following:

“(c) **UNIQUE HEALTH IDENTIFIERS.**—Notwithstanding subsections (a) and (b), the Secretary may not promulgate or adopt a final standard under section 1173(b) providing for a unique health identifier for an individual (except in an individual’s capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard or containing provisions consistent with the standard.”.

The SPEAKER pro tempore. After 1 hour of debate on the bill, as amended, it shall be in order to consider the further amendment printed in the CONGRESSIONAL RECORD numbered 2, which shall be considered read and debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

The gentleman from Illinois (Mr. HASTERT) and the gentleman from Michigan (Mr. DINGELL) each will control 30 minutes of debate on the bill.

The Chair recognizes the gentleman from Illinois (Mr. HASTERT).

□ 1045

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GOODLING), the distinguished chairman of the Committee on Education and the Workforce.

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

Mr. GOODLING. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. This is truly a historic occasion which rivals the passage of ERISA in 1974. Thanks to ERISA, 150 million Americans are covered by employer-sponsored health care plans. Thanks to the gentleman from Illinois (Mr. FAWELL), most of the 4 million uninsured will have quality affordable health coverage available to them when we pass this legislation.

Increasingly, the American people tell us that they need common sense elements in health insurance reform,

and that is what is in the Patient Protection Act, including basic protections such as guaranteed access to emergency medical care, doctors being able to speak freely with patients about their health care options without being gagged and ensuring that a patient can quickly obtain the benefits promised by their health care.

The Patient Protection Act will also provide health care accessibility to patients by requiring that patients have full access to plan information such as what benefits are covered, the participant’s financial responsibility, and a complete description of the claims procedure and appeals process. Women and families with small children will be ensured direct access to key specialists such as OB/GYNs and pediatricians.

As I see it, however, our plan differs from other proposals in two key ways. First, we make sure that patients get the care they deserve in a timely manner before harm can occur. We get them into hospital rooms, not into courtrooms.

We take serious, comprehensive steps to expand availability and affordability of health insurance to American working families who have no health insurance. No other plan does this.

I have held a lot of town meetings in my district over the years, and not once has a constituent said to me, “I would really like to be able to sue my health plan.” What they have said to me over and over again is “When are you going to do something about the high costs of health insurance?” Today, I am happy to say we are doing something about it.

Simply put, the Patient Protection Act will increase access to affordable health insurance for millions of Americans. It is amazing to me that all the other proposals ignore the 42 million uninsured Americans.

The gentleman from Illinois (Mr. FAWELL) has pushed this through our committee on two occasions to make sure that we do something about the uninsured. The problem of the uninsured, both children and adults, is the problem of small business lacking access to affordable health coverage.

Over 80 percent of the 82 million uninsured Americans live in families where someone is working, someone is employed usually by a small employer, or they are self-employed.

To address the affordability problem of the uninsured, the Association Health Plan proposals in the Patient Protection Act would give franchise networks, bona fide trades, business and professional associations, and organizations such as the Chamber of Commerce, and the National Federation of Independent Business the ability to form large group health plans within and across State lines.

Again, the best patient protection is access to affordable health care.

I would like to take a minute to go into a little more detail about some of the claims procedure provisions in the Patient Protection Act as they pertain to ERISA.

The provisions relating to internal review and external review claims procedures and remedies are contained in Subtitle C of Title I and will hold plans accountable and insure patients get the care they deserve in a timely manner.

The current claims procedures that apply to employee benefit plans under federal law are contained in ERISA Title I section 503. The exclusive remedies that apply to such plans are contained in Part 5 of that Act. With minor exception as provided in regulations, the procedures under 503 do not distinguish between group health plans (i.e. employee benefit plans providing medical care) and other plans, including pension plans and other employee welfare benefit plans. In general, plans may take up to 90 days to inform claimants of initial decisions and up to 60 days to inform them of decisions upon internal appeal. Generally, upon satisfaction of administrative remedies, claimants may proceed, pursuant to Part 5, to enforce their rights under the plan and the ERISA law in court. In general, remedies relating to adverse coverage decisions are limited to the payment of benefits as found to be provided under the terms of the plan and to such reasonable attorney's fees as may be provided in the discretion of the court. Certain other civil remedies may also apply.

Under Subtitle C of Title I the ERISA claims procedures are modernized to take into account the rules as they apply to the many diverse kinds of group health plans in today's evolving health care delivery system. Section 503 of ERISA is amended to require group health plans to provide written—and understandable—notice to a participant of any negative coverage decision on requested benefits under the plan within 30 days of the request. If the request is for urgent medical care, the plan must provide the notice within 10 days; for emergencies, the requirement is 72 hours. If the request is for a referral to a physician specialist, the coverage decision must be within 72 hours. This notice also must be sent to the participant's medical provider if the provider initiated the claim or seeks reimbursement from the plan. The participant must be informed in the notice that he or she may file a written request for review (i.e. internal appeal to an appropriate named fiduciary under the plan) of the coverage decision within 180 days after the notice is received. Internal reviews of coverage request denials involving medical necessity and experimental treatment or technology must be conducted by a physician who did not make the initial decision. The same time frames apply to internal review as to the initial coverage decision.

If the internal appeal results in a coverage denial, the participant may make a request within 30 days for an external review, which must be conducted by one or more independent medical experts (in general, a physician with expertise in the matters involved) selected in accordance with procedures that must be specified under the plan. The procedures of selection required under the plan allow for independent intermediaries to select the reviewing medical experts so as to ensure they meet the strict independence rules preventing conflict of interest. The external review must be completed within 25 days of the request. If the final decision under the plan by a physician, who did not make the earlier decision, is an adverse coverage decision, then the participant has recourse to the courts. Al-

ternative dispute resolution procedures would be permitted, however they would have to conform to the requirements for physician review of medical necessity and with the external review procedures.

The remedies under section 502 of ERISA are improved to include civil penalties for fiduciaries who do not provide benefits in accordance with the recommendation of the external review medical expert. If after external review, a participant is denied coverage, a civil court may impose a penalty of up to \$500 a day (\$1,000 in the case of bad faith violations) starting on the date on which the recommendation was made. The total penalty may be up to \$250,000. Also, fiduciaries in an expedited court action or who took or failed to take action that resulted in a denial of coverage after an external review would be liable in such court actions to pay attorney fees and other reasonable costs to the plaintiff—i.e., the patient. In the case of a pattern or practice of violation, the Secretary of Labor may, in a court proceeding, impose a penalty of up to \$100,000. In cases in which a physician certifies to a court that the time needed to carry out administrative remedies and procedures for review of coverage denials would run the risk of causing irreparable harm to the health of the participant, the provisions under section 502 allows such participants to take civil action to obtain an injunction or other equitable relief.

This claims process will ensure patients get the care they deserve in a timely manner. It is one of many reasons the Patient Protection Act should be passed by Congress and signed into law.

Mr. DINGELL. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, we face a clear choice today between two different approaches. The first, the Patients' Bill of Rights was written last year and revised in March. The other piece of legislation, the Republican leadership bill, was still being written after midnight last night.

The Patients' Bill of Rights has been scored by the CBO at a cost of \$2 per month per patient, and we provided revenue offsets to ensure fiscal responsibility.

The leadership's bill was never even seen by the CBO and has not been read by the Members. Only minutes ago did we get a final score from CBO. Since it does nothing, it costs nothing. I think my colleagues should note, a bill that does nothing costs nothing.

The Patients' Bill of Rights guarantees real patient rights. It puts health back into the Health Maintenance Organization. The Republican leadership bill has the word HMO. In that bill, HMO stands for hide my opposition.

If our primary concern is health care for the American people, the choice is clear. The Patients' Bill of Rights puts medical decisions, especially the question of medical necessity into the hands of doctors and takes them away from insurance company bureaucrats who now are hurting the American public.

The Patients' Bill of Rights guarantees that we can see a medical specialist when we need one. The Patients'

Bill of Rights says that, if you are a pregnant woman or cancer patient, you will continue to be able to see your doctor when you need continuity of care.

The Patients' Bill of Rights guarantees that we will be able to get the prescriptions that we need. The Patients' Bill of Rights holds health plans accountable when they have denied health care and when their decision kills or injures somebody.

The Patients' Bill of Rights protects the confidentiality of our medical records, and the Republican bill does not. The Republican bill even has one interesting thing. It goes so far as to repeal existing consumer protection laws that help patients. I want my colleagues to hear that.

Last of all, I want my colleagues to look at the roster of supporters of the Patients' Bill of Rights: AMA, all the health care specialists, the nurses, and all of the consumers and aging organizations. The American people want the Patients' Bill of Rights. If we want to serve them, we will vote for the Patients' Bill of Rights today.

I want to particularly single out my good friend and colleague, Dr. GANSKE for his leadership and courage on this issue. He is a man of integrity and stands up for what he believes in. He deserves great credit.

I also want to commend the work of the staff in the development of the Patients Bill of Rights.

Among our staff Bridgett Taylor, Amy Droskoski, and Bernadette Fernandez have worked tirelessly on the bill for many months.

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Virginia (Mr. BLILEY), chairman of the Committee on Commerce.

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

Mr. BLILEY. Mr. Speaker, when it comes to health care, patients and their doctors should be in the driver's seat. Right now, they are mere passengers. Fortunately, the Patient Protection Act of 1998 puts patients back at the wheel where they belong.

Our bill gives Americans the care they need when they need it. It protects patients without expanding big government, and it promises patients greater choice and the ability to stick with a favorite doctor.

The Patient Protection Act addresses a major flaw in our health care system, the lack of a real marketplace where patients can shop for the lowest cost and highest quality care.

Even Ron Pollack of Families U.S.A., a staunch supporter of President Clinton's efforts to nationalize health care agrees this is needed. He recently said, and I quote, "There is no true marketplace today to drive health care quality." He is right. Think about it.

When we buy a new car, we do not go to a bank, credit union, or GMAC first. We choose the car we want; then we arrange the financing. In other words,

we, not the lender, choose what car to buy. We, not our employer, choose the financing.

Why can health care not work the same way? Why do health care choices have to be dictated by the terms of health insurance than by consumers' needs and preferences. Why must employers choose the health coverage that finances so many Americans' care?

HealthMarts answer these important questions in a way that puts patients first. HealthMarts are private, voluntary, and competitive health insurance supermarkets. They transfer choice within the employer-based health insurance market from small employers to employees.

HealthMarts give consumers the freedom to choose health coverage from a broad menu of options. Here is how they work: A small business joins a HealthMart because it offers lower cost coverage, makes more options available to employees, and does the administrative work.

Employees choose from among the HealthMart's coverage options. Each can choose a different plan and still benefit from group rates. Sound familiar? It should. It is the type of choice today that is available only to Members of Congress, our staffs, and other Federal employees.

This type of consumer choice is essential to the quality of health care coverage and services. After all, if all Americans had the freedom to choose their coverage, they would be able to get the highest quality care that best meets their needs. HealthMarts will achieve that critical objective.

The bottom line is this: By making quality as important in the selection of health coverage as cost, HealthMarts will move the Nation toward a true health care marketplace.

This new idea gives patients more choice and better quality health care. It puts them back in the driver's seat. It is yet another reason why the Patient Protection Act deserves our strong support.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE) and note that he has been instrumental in bringing us to where we are today. I salute him for it and thank him on behalf of my colleagues.

Mr. GANSKE. Mr. Speaker, I rise in opposition to H.R. 4250 and in support of the Ganske-Dingell substitute. There is going to be a lot of debate today about the legal situation. I have been for legal reform. I have stood in this well arguing for medical malpractice reform. I voted for securities litigation reform, product liability reform.

I, as a physician, would never want Congress to pass a law that says physicians should be immune from their malpractice. Yet, that is a situation that we have with ERISA.

The problem with H.R. 4250 is it does not remove ERISA preemption for

State causes of action. The Ganske-Dingell bill says that Federal law may not preempt State law, but we have a provision in there that protects the employer.

If the employer is not making the decision, if the HMO is making the decision, the employer is not subject to liability. That is a very important distinction. It is fair.

But let me just ask my colleagues something, it is very clear that HMOs have committed malpractice that has resulted in loss of life and limb. ERISA, through the interpretation of the courts, has extended that legal exemption to health plans. However, we have never had our personal fingerprints on that legal immunity and the problems with it.

If we vote for the GOP bill, we are going to be codifying, giving HMOs legal immunity. Would we do that for tobacco companies? I think not. Would we do that for companies that are making life and death decisions? I hope not.

Mr. HASTER. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. CUNNINGHAM).

Mr. CUNNINGHAM. Mr. Speaker, I have no doubt that Members on both sides of the aisle want to focus on health care, but I personally feel that, in an election year, political pandering on both sides is not a benefit for the American public.

I look at the Democratic "Bill of Fights" that is going to drive up health care cost by letting trial lawyers take over. California is a leader in HMOs, but I also see good, bad, and ugly in the HMOs in California. We are losing good doctors in California because of HMOs and managed health care.

□ 1100

But yet there are still some good ones, and we need to attend to that.

Whether the lawyers drive up costs or CEO's from HMOs rip off the system and drive up health care, both are bad, and that is why I say that neither one of these bills are good for the American consumer, and we need to help.

The gentleman from California (Mr. FAZIO) brought over a list of things that are preempted in state law. I do not want that. But, at the same time, I looked into it, and the unions right now are under ERISA. Your supporters are exempt under state law, the unions and large companies. We wanted the small businesses to be able to band together and have the same benefits for low health care costs.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from California (Mr. STARK).

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

Mr. STARK. Mr. Speaker, I ask unanimous consent that my infirmity not be taken as support for the Republican bill, which is a cynical sham and should be defeated. I wish to announce my support for the Dingell bill.

Mr. Speaker, today's vote on managed care reform is a complete sham.

It wasn't long ago when the Republican leadership called on their friends in the health insurance industry "get off your butts and get off your wallets" to defeat real reform.

Today, they are here to put another nail in the coffin of real reform.

Their answer to managed care reform is the same as their answer to campaign finance reform and tobacco legislation: Make it look like they are doing something, but then work to kill it with the addition of divisive provisions.

H.R. 4250 flunks the fundamental test of real reform—it doesn't hold health plans accountable for their medical decision making. This bill precludes an injured patient or their family from suing a managed care plan that maims or kills them.

Under the Republican bill, health plans could continue to get away with cases like that of Mrs. Florence Corcoran, who lost her baby because of her health plan's refusal to follow her doctors' advice.

Today, if a doctor commits malpractice on a patient, the patient has the right to sue that doctor. If a hospital maims a patient, they are liable for their action. If a defective car causes a person's death, the care manufacturer is liable.

Why should we let managed care plans off the hook? What makes them worthy of legal immunity that we don't grant doctors and hospitals—or any other profession or industry?

In addition, the Gingrich managed care bill before us today includes a number of "poison pills" that Congress has rejected numerous times in the past.

Among the poison pills are:

Expansions of medical savings accounts to help the healthy and wealthy at a cost of billions to American taxpayers;

MEWA and HealthMart provisions that would destroy small group market reforms in the states, increase adverse selection and weaken state enforcement authority.

But the cherry on top of this sundae for the managed care industry is the permission this bill gives health plans to withhold even more access to care than they can under current law. This bill gives HMOs the right to define—each plan for itself—what the medically necessary care is that it will provide to its enrollees. Today, medically necessary care is defined by doctors and other medical experts as the best that science and human ability can deliver. But this bill says plans can decide what their version of medically necessary care is, and how much of it they will give you. It lets bureaucrats, not doctors, determine your health care.

Even those managed care reforms where there has been widespread agreement—such as access to emergency care—are botched in the Gingrich bill.

This bill does not provide the protections to the private sector that are enjoyed by Medicare and Medicaid beneficiaries today.

An emergency physician who testified earlier this week, Dr. Charlotte Yeh, got it right when she said that she thought the Republicans had performed some "unnecessary surgery on the prudent lay person standard to the point where it is hardly recognizable as the consumer protection we envisioned."

The Gingrich bill destroys medical record confidentiality. It would trample on Fourth Amendment rights by giving health plans and

health providers the right to disclose your medical record to any entity—without your permission. Your medical record, with your name and full history, could wind up in the hands of a drug company's marketing department . . . a credit card company . . . a consultant working on a political campaign . . . a divorce lawyer . . . a newspaper.

The public deserves better from Congress than this shoddy piece of work.

This bill also allows plans to charge people up to \$100 to get external appeals—and doesn't allow patients or doctors to present any evidence at that external appeal review. Talk about a sham!

This Republican bill is worse than doing nothing. If Members of Congress took the Hippocratic oath to do no harm, they would not be able to vote for this bill. Vote to defeat H.R. 4250.

I support the Ganske-Dingell substitute. It is a real bill, with real protections.

The Republican bill is a sham. It provides none of the major consumer protections that patients need.

The Republican bill actually does harm. It overrides hundreds and hundreds of State consumer protection laws, leaving people with less protection than they now have. It will drive up the cost of health insurance for most people. It makes your most private medical records available to every Tom, Dick, and Harry salesman. It spends billions on a new tax break for the wealthiest and healthiest in our society. It takes away your right for compensation for pain and suffering because of medical malpractice.

These harmful features are poison pills, designed to cause controversy and confusion in the Senate and to prevent a bill from passing. The Republican bill is another testament to the need for campaign finance reform: it is a bill designed to make their PAC contributors happy.

The Democratic substitute bill, on the other hand, is a real patient protection bill endorsed by the doctors, by the nurses, and all the consumer groups.

It will require that health plans provide you care that is based on the consensus of the latest, best quality of care. The Republican bill, on the other hand, lets each profit-making HMO define what they believe is adequate medical care: they will provide care based on what their accountants tell them—not their doctors.

The choice could not be clearer. We can pass the Republican sham bill today—or we can pass a real bill—the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the gentleman from Missouri (Mr. CLAY) the ranking member on the Committee on Education and the Workforce.

Mr. CLAY. Mr. Speaker, I rise to oppose H.R. 4250. This bill is nothing more than a cynical propaganda effort promoted by the Republican leadership to convince the public that they are doing something about the abuse of HMOs. This bill is loaded with special interest provisions that do far more harm than good to consumers of health care.

The Republican bill includes a provision to establish Association Health Plans that would enable small busi-

nesses and self-employed individuals to band together and purchase health insurance coverage. The chairman of our Committee on Education and the Workforce has stated that the committee has approved this provision and so no one should be concerned about it. The fact is, the bill was reported over Democrat's vehement objections, because it is clear that the arrangements will do more harm than good.

The National Governors Association and the National Conference of State Legislators join with the National Association of Insurance Commissioners in stating that Association Health Plans would undermine positive state regulatory reforms already in place, would destroy important consumer protections, and would contribute to the collapse of small group health insurance in many states.

According to CBO, Association Health Plans would increase the risk of health plan failure and would disrupt the insurance market, because Federal regulatory standards would probably be less strict than the state standards that apply under current law. Association Health Plans would present state regulations covering such vital matters as sovereignty, mandated care and the policing of fraud and abuse.

Mr. Speaker, I urge my colleagues to reject H.R. 4250 and instead support H.R. 3605, the bipartisan Patients' Bill of Rights act.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the distinguished gentleman from Texas (Mr. ARCHER), the Chairman of the Committee on Ways and Means.

Mr. ARCHER. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, two principles have forever guided our Nation, individual freedom and liberty. As a democratic Nation whose strength derives from its people, we have achieved high degrees of each, unsurpassed by any nation in all history. It is no wonder that people around the globe want to come here and be called Americans. We are the envy of the world. Now, as we consider a plan to protect and strengthen a free people who worry about the health care needs of themselves and their families, we must do so with our guiding principles in mind.

Our Nation's health care system is the best in the world. Americans do not travel abroad to get health care, but visitors come here from all over the world, to the Mayo Clinic, to Mount Sinai, and, yes, to my own City of Houston to the Texas Medical Center Memorial, because we are the best.

The reason our health care system is the best is because it is based on capitalism, on choice and on individualism. That is why the one aspect of the bill before us today that gives me great pride is the expansion and the unfettered opportunity for Americans to choose medical savings accounts, free and unencumbered.

The source of America's frustrations with HMOs is the lack of control which

both patients and doctors feel. There is always a third party making a decision. Patients want to be able to pick up the phone and get a quick appointment to see their doctor. Patients want to see the doctor of their choice for all their health needs.

Doctors want to take more time to be with their patients. Doctors want to treat their patients as they see fit, without interference from a third-party payer or an insurance company, and that is why we need medical savings accounts. With MSAs, patients, not insurance companies, control their choices. There are no gatekeepers, there are no middlemen, and there are no third-party payers, except in the case of a catastrophic event.

MSAs let patients and employers deposit money tax-free into accounts that patients control. Like an IRA for retirement needs, MSAs are IRAs for health care needs. When people control their own money, the general use of capitalism will come into play. It has in all things American; it will in health care too.

Our Nation's greatness is based on freedom and liberty. So, too, is our future. While I originally introduced this bill with a Democrat Congressman, Andy Jacobs, six years ago, I realize even more today that MSAs are and should be the future of health care.

I urge support of the bill.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the distinguished gentleman from Texas (Mr. HALL).

Mr. HALL of Texas. Mr. Speaker, I would start by saying that my speech will probably fall on some closed minds, because many already have your minds made up. Many of you have decided or pledged to take a particular vote, or taken an oath to do it, or been whipped by either the Democrat or Republican Whip.

I speak though to those who do not have their feet set in concrete today, I think those that really and truly want the facts about this situation.

I did not speak on the rule. As a matter of fact, I voted for the rule. I think it is about as fair a rule as a majority will give a minority, so I had no problem with the rule. The rule was not good, but I think the worst is yet to come, and let me talk about a little of it.

It does not please me, by the way, to oppose the likes of the U.S. Chamber and the NFIB. I have had 100 percent with them for years and years, but I differ with them on this because I think they are wrong.

I think that ERISA is what this is all about. ERISA is what all these meetings have been about. ERISA is what the insurance companies can hide behind to escape liability, and it is not right, it is not fair, it is not just, and it should have been changed.

All the conferences that have been had over on this side, all the committee meetings, way into the night, last night, late, late, late, war gaming amendments, it is how can we compromise ERISA? That is what the

whole thrust has been, how can we keep ERISA on the table for insurance companies to hide behind when they err, when they guess wrong?

I tell you, H.R. 4250 preempts states patient protections too. I think we need to know that. This bill will remove stronger patient protection bills in over 40 states. I think the facts are out on the sheet that show how your various states are affected.

Tonight we are going to finish this. We are going to go home, we are going to issue press releases carefully worded, but the hard cold fact is you are offending people when you leave ERISA in place as a hiding place for those that ought to be liable.

Mr. Speaker, as I close, I urge Members to vote against 4250.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the distinguished gentlewoman from New Jersey (Mrs. ROUKEMA).

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I must tell my colleagues that I rise in reluctant opposition to this bill, and I am constrained to ask, not facetiously, is this as good as it gets? I am sorry, that is a facetious reference to the movie that we all say identified the backlash out there, and that backlash has promoted our party, both parties, to seek a solution. But I do not believe that this bill is as good as it should get.

I wanted to say that I recognize that there are a lot of benefits to the Republican task force bill, but we have to go beyond that.

Let me point out the issues that are of continuing concern to me. I do not believe we have the patients' access to clinical trials that they need. I do not believe there is expanded access to specialists in a meaningful way, and that is very important to me. I think that the external appeals process, as I read it, and, of course, we only got it really this morning, but as I read it, the appeals process is not even binding. This concerns me, because a right without enforcement is no right at all, as far as I can tell.

I do also want to get to the point of the ERISA question, the health plans. I want to particularly reference the fact that I believe that the gentleman from Iowa (Mr. GANSKE) in his analysis was absolutely correct, and I agree with him. I am concerned that this ERISA preemption as it is supplied to the Association Health Plans and the HealthMarts would be an expanded loophole to legitimate care, particularly for the small business community employees, and I am deeply concerned about that.

These potential loopholes would greatly diminish the quality of care and the medical protections in states such as New Jersey. This is a prime problem. We can have these association pools, we can do these small business pools, without expanding the ERISA preemption.

So I must reluctantly again say, bottom line, the question is whether or not patients will have better access to health care, and health care through the doctors and the professional health care providers, not bureaucrats.

INTRODUCTION

I rise in reluctant opposition to the bill placed before the House today. And I am constrained to ask: Is this "As good as it get?" This is my own reference and its not facetious to the motion picture that made graphically clear to policymakers the backlash I long ago predicted against HMOs. This building backlash was the reason I introduced my own bill H.R. 1222, "The Quality Health Care and Consumer Protection Act" in 1996 to focus the debate.

Today I say that this bill is clear movement in the right direction. But it is not "as good as it should get."

We need to put health care decisions back in the hands of doctors and other health care professionals, and take them away from the managed care companies who are practicing "bottom line" medicine and "rationing" healthcare.

It is for this reason that I introduced legislation to ensure that managed-care networks provide high-quality, efficient care, not just low-case care that boosts profits. But at the same time my bill guards against unjustified health care costs.

CONCERNS WITH TODAY'S HURRIED PROCESS

But today I must decide between one of two proposals. Before I discuss the proposals I do want to raise a concern with the process.

The state of our nation's health care is an issue that should be debated through Committee discussions, through hearings, and through floor debate, instead of a limited up or down vote.

BENEFITS OF THE REPUBLICAN TASK FORCE BILL

The bill we have before us today is not altogether bad. There certainly are areas that could use significant improvement; however, the base bill does include information disclosure, internal and external appeals and grievances, a ban on gag clauses, and access to OB/GYNs and pediatricians. These are all moving in the right direction.

However, we are not yet there! Again, this is not "As Good As It Should Get!"

PROBLEMS WITH THE REPUBLICAN TASK FORCE BILL

This bill does not include a provision to provide patients access to clinical trials, expanded access to specialists, and physician involvement in the development of drug formularies.

This bill also has an external appeals process that is not even binding. This concerns me, because it is a right without enforcement. And a right with no enforcement is no right at all!

In addition I am concerned this legislation does not have a provision relating to provider incentive language to ensure that physicians and pharmacists are consulted in the development of drug formularies when medically necessary.

ASSOCIATION HEALTH PLANS AND HEALTHMARTS

I am also deeply concerned about expanding the ERISA pre-emption to even more businesses than those already able to escape State laws.

We must carefully weigh the benefits of allowing associations the protections of being

covered by national laws with the benefits of allowing state laws to determine consumer protection. Association Health Plans and HealthMarts would both allow more people to escape the coverage of state laws. These are potential loopholes that would diminish necessary medical protections in states such as New Jersey.

Businesses have long argued that ERISA is necessary for companies that operate in more than one state because it avoids the onerous burden of complying with 50 different sets of regulations and offering 50 different sets of rules and coverage for their employees. This is a valid argument.

However, in today's market, this has led to loopholes where employers are able to avoid the protections fought for, and placed at the state level. I agree with Dr. Ganske's analysis of how inadequate this provision is.

RIGHT TO SUE

I must also address the right to sue. While I understand the merits to this important right, I am also very concerned that this right would add tremendous costs and affect the quality of health care—doctors and HMOs and hospitals would be practicing defensive medicine—namely executing procedures and conducting tests merely to protect themselves against lawsuits. This concerns me, because this could lead to a reduction in the number of people able to afford health care.

CONCLUSION

The bottom line is whether patients will have better access to health care and whether doctors and health care professionals will be put back in charge instead of insurance company bureaucrats. We need to return the power over medical decisions to those with the medical training and expertise—the doctors and the nurses. This will restore the quality of care that has been our American tradition and leave the field of "bottom line medicine" practiced by bureaucrats and so-called "gatekeepers."

Mr. HASTERT. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, I would like to just remind the gentlewoman from New Jersey that the people that we are bringing under the umbrella of new health care do not have health care today, part of the 40 million people who work for a living, who are out there that do not have health care. We are trying to expand and bring those people under the umbrella of health care.

Mr. Speaker, I yield two minutes to my colleague, the gentleman from Illinois (Mr. FAWELL), the distinguished chairman of the Subcommittee on Employer-Employee Relations, and certainly someone who has worked on this issue of bringing people under the umbrella of health care for a long time.

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

Mr. FAWELL. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, right now there can be no patient's bill of rights for 43 million people, because they have no access to affordable health care, and we can change that in this legislation with Association Health Plans.

What do Association Health Plans do? By allowing small businesses to

band together under multiple employer health plans, Association Health Plans simply allow the little guys, the small businesses, the self-employed, to have precisely what large employers have had for many years. Thus, small businesses can gain the economies of size, so they can do what, self-insure, and thereby they have the clout to bargain and to discount the price of health care in dealing with health care providers and in dealing with insurance companies.

□ 1115

Who are these association health plans? They are long-standing and respected, not-for-profit, professional business and trade and church associations which, like the large employers, they are not in the business of insurance, but that they will, like large employers, assume the responsibility of sponsoring self-insured and fully-insured plans for the members of their associations.

Examples of these associations, yes, include the National Chamber of Commerce and the NFIB, the National Restaurant Association, but also include the Agricultural Field Workers Association, who cannot get health insurance in the market. National Church Associations, National Farm Bureau, the Boys and Girls Clubs of America with 700 units, and they cannot get regular indemnity policies.

Why are the association health plans important? Because most of the 43 million people who do not have health insurance in America, including most of the uninsured children, are people who live in families with the breadwinners employed by small business or are self-employed. They have to simply go into the individual and small business market, and my colleagues know what happens when one goes into that individual and small business market. The insurance companies and the HMOs do not want to give up and have new competition.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the gentleman from Minnesota (Mr. OBERSTAR).

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

Mr. OBERSTAR. Mr. Speaker, I rise in opposition to the bill before us and in support of the Dingell substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. FORBES), my distinguished friend.

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

Mr. FORBES. Mr. Speaker, I thank the gentleman for yielding me this time.

For an increasing number of years now Americans across this country have made it clear that they are dissatisfied with the manner in which some health maintenance organizations oversee the delivery of their health

care services. In fact, just a few years ago the "hue and cry" got so loud that on this floor, this very floor, a bipartisan majority of Democrats and Republicans saw fit to pass legislation that corrected the practice of some insurance providers that forced women out of the hospital barely 24 hours after they gave birth.

Yes, the House and Senate together, along with the President, decided that it was wrong and we must mandate, yes, mandate a minimum hospital stay for women who give birth.

Well, unfortunately, that is not the sole example of some of the problems with the HMOs and that is why we are here today. Unfortunately, the Republican initiative, which I would have loved to have supported, does not adequately meet the needs that most Americans are calling for.

The Patients' Bill of Rights, in fact, is the best alternative to restoring common sense in the HMO equation. Only the Patients' Bill of Rights allows patients access to key clinical trials, those experimental, innovative and emergency processes that are the last resort for the severely ill. The Patients' Bill of Rights gives access to important drug therapies that a doctor may believe are important to restoring one's health and cost thousands of dollars and would otherwise mean literally life or death for the patient.

A gross omission in the Republican bill, I am afraid, is something even worse than the early release after giving birth, and that is the so-called omission of preventing drive-by mastectomies, the practice that too many HMOs use to force a woman who has undergone a mastectomy out of the hospital before she is physically able to resume normal activities.

Absent, too, and I believe it should be her right, that every woman who has undergone a mastectomy have the right to access to reconstructive surgery and not have it deemed cosmetic by an uncaring HMO.

Finally, the Patients' Bill of Rights is the only one that ends the special protections for HMOs under ERISA. HMOs should not be exempt from lawsuits if bad decisions lead to injury or death.

Mr. Speaker, I urge adoption of the Patients' Bill of Rights by the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE).

Mr. HASTERT. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Louisiana (Mr. McCrery).

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

Mr. MCCRERY. Mr. Speaker, if one believes in the free market, if one believes in the power of individual choice, if one believes our private health care system is, in most respects, the best in the world and is worth preserving, then listen up.

I am going to tell my colleagues about the best part of the Patient Pro-

tection Act. It is the part of this bill that really empowers patients. It gives them the ability to choose their own doctors and hospitals. It gives them the economic power to deal effectively with the costs of their health care. It gives individuals the power to take advantage of preventive health care, if they choose. It even offers people the prospect of a sizable nest egg in their later years which they could use for long-term care expenses or retirement.

Mr. Speaker, this Patient Protection Act will finally make medical savings accounts available to everyone, and it removes the burdensome regulations that have prevented many individuals and small businesses from obtaining MSAs. This bill allows both small and large employers to make deductible contributions to an employee's MSA. It allows both employers and employees to make tax-favored contributions to a medical savings account.

Mr. Speaker, if we really want people to be able to take control of their health care choices, if we really want to make the doctor-patient relationship what it used to be and what it should be, if we really want to create a market with forces that can control health care costs, then we must be for the expansion of this valuable, free market tool: medical savings accounts. That alone should make my colleagues vote for this bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I rise in opposition to H.R. 4250 and in support of the Dingell-Ganske bill. The Republican bill is bad for small business, bad for America, and it is shameful. It is a fiscally-irresponsible sham that does nothing to address the real concerns of employers, employees and real people.

This legislation creates a new Federal Commission of Insurance at the Department of Labor, a Department that my Republican colleagues tried to do away with just 2 years ago. It authorizes the hiring of hundreds, perhaps thousands, of new employees at a new Federal Commission of Insurance.

What will this new Federal Commission do? Absolutely nothing. Because its powers are so limited by the Republican bill that its ability to remedy health plan wrongdoing is almost nil.

How much will this new Republican Federal Insurance Commission cost? No one knows, because we still have not seen a CBO score.

Let us see. A multimillion dollar new Federal bureaucracy, thousands of new employees with nothing to enforce, all at the American taxpayers' expense, release of medical records. Your competitors in business, your opponents in politics will have access to your medical records. Protection of insurance company profits, abuse of patients, no access to emergency care or specialists. My Republican colleagues should be ashamed.

Have my colleagues read this bill? My colleagues will be shocked. I urge

my colleagues to vote down this irresponsible proposal. Vote for the Dingell-Ganske substitute. This Republican proposal is a useless drain on our Treasury and a threat to our balanced budget.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. CHABOT).

Mr. CHABOT. Mr. Speaker, I rise in support of the Patient Protection Act. There have been numerous managed care reform proposals offered in Congress this year, and many share similar consumer protections.

The Patient Protection Act guarantees that patients can choose their own doctor, gain access to emergency care, communicate openly with health care providers, and independently appeal decisions made by managed care companies.

This bill also contains a number of pro-consumer provisions that the other proposals do not. This legislation increases patient access to affordable care by expanding health care coverage options for workers and their families, many who have no health care coverage at all now.

American families know that the most important patient protection is access to affordable care. Families should not be forced to choose between expensive health care coverage and putting food on the kitchen table.

This legislation will protect consumers from abuses in the managed care industry, while increasing access and affordability. That is why I support the Patient Protection Act.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT).

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

Mr. MCDERMOTT. Mr. Speaker, as the public listens to this debate, I am sure they will wind up confused, so I want to give 10 reasons why my colleagues should vote against the Hastert proposal and for the Ganske-Dingell bill. I borrowed these from the gentleman from Iowa (Mr. GANSKE) who is a Republican and a doctor. I am a Democrat and a doctor, and we agree.

He says, the substitute provides, that means the Democratic substitute, patients with access to clinical trials. The Hastert bill does not.

The substitute allows doctors to override drug formularies when medically necessary. The Hastert does not.

The substitute provides for ongoing access to specialists for chronic conditions. The Hastert bill does not.

The Ganske-Dingell substitute prevents plans from giving doctors financial incentives to deny care. The Hastert bill does not.

The substitute has hospital-stay protection for mastectomy patients. The Hastert bill does not.

The substitute provides choice of doctors within the plan. The Hastert bill does not.

The substitute has a provision guaranteeing continuity of care when pro-

viders leave the network. The Hastert bill does not.

The Ganske-Dingell plan requires plans to collect quality data and maintain a quality improvement program. The Hastert bill does not.

In addition, the Hastert bill allows the plan to decide what is medically necessary. If one has chest pain and one feels like one should go to an emergency room, one cannot decide whether that is medically necessary, one's plan will tell you if it was medically necessary. Maybe after you get to the hospital, they will say, well, it is just indigestion, so it is not medically necessary to go to an emergency room.

There are more reasons than I can get in in 10 minutes. This cynical process requires a "no" vote on Hastert and a "yes" vote on Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield myself 30 seconds.

I appreciate the gentleman from Washington, who is a doctor and certainly sees things from a different perspective, but I have to tell my colleagues he named 10 mandates that our bill does not have, 10 mandates. And he also talked about the Federal Government, the HCFA agency starting to lay out what one's health plan should do and what it should not do.

The gentleman from Washington has certainly been an advocate of big health care, government takeover of health care, and that is exactly what this plan is not, and I want the people in this country to know that. We think the decision on what one owes health care should be between the patient and the doctor, and that is exactly what this bill does.

Mr. Speaker, I yield 3 minutes and 15 seconds to the gentlewoman from Texas (Ms. GRANGER) for the purpose of a colloquy.

Ms. GRANGER. Mr. Speaker, I rise today in support of H.R. 4250, and I thank the gentleman from Illinois (Mr. HASTERT) and all of the members of the working group for their ability to listen and their desire to lead.

It has often been said that there is a time in the life of every problem when it is large enough to see and yet small enough to solve. The issue of health care reform is one we can see and solve, and our bill does that.

The Republican goal is to provide quality health care and peace of mind for every American. The Republican plan gives peace of mind when the nearest emergency room can mean the fastest care in the case of a heart attack. Our plan gives peace of mind for mothers because there is no barrier for care by a pediatrician. Our plan gives peace of mind for women because they can go directly to an OB-GYN for their health care. And our plan gives peace of mind for small businesses because they will have choices for their health plans through health marts and association health plans.

□ 1130

Overall, our bill gives HMOs accountability to their patients, not their prof-

its. Our bill says that doctors, not bureaucrats, will be authorized to make medical decisions.

Our bill is the only bill that would provide affordable health care to millions of uninsured Americans. Even Senator DASCHLE agrees with us on that.

In short, our bill, the Patient Protection Act, will ensure that all Americans have access they deserve to the health care they need at a price they can afford.

Mr. Speaker, at this time I would like to engage the gentleman from Illinois (Chairman FAWELL) in a colloquy. Among the most important protections that this legislation affords to patients is the right to internal and external review of decisions made by HMOs. Those reviews will be made by qualified independent doctors.

My home State of Texas has a law that allows HMOs to be liable in court. There is some uncertainty as to whether or not and the extent to which this Texas law is preempted by the ERISA law. In fact, this is a question that is before the courts.

Mr. Speaker, I would like to engage in a colloquy with the gentleman from Illinois regarding the possible effects of this new legislation's internal and external review procedures on whether the ERISA law preempts the State statute.

As one of the authors of this legislation, the principal author of the internal and external review procedures, and one of the leading experts on ERISA, are these new procedures intended in any way to indicate congressional intent about whether the Texas State law is preempted by ERISA?

Mr. FAWELL. Mr. Speaker, if the gentlewoman from Texas (Ms. GRANGER) would yield, no, they are not. The more explicit internal and external review provisions under this new legislation do not and are not intended to expand or contract existing ERISA law.

Therefore, these new procedures do not and are not intended to affect whether or the extent to which ERISA does or does not preempt any particular State statute. These new procedures do not indicate congressional intent either way about whether Texas law is preempted by ERISA.

Ms. GRANGER. Mr. Chairman, reclaiming my time, are the legislation's more explicit internal and external review procedures intended to in any way affect the outcome of any matters pending in court examining the extent or scope of ERISA preemption of State laws?

Mr. FAWELL. Again, no, they are not. The legislation's more explicit internal and external review procedures under ERISA are not intended to expand or contract existing provisions of law. Therefore, it is not intended to have any impact on pending litigation examining the possible scope of ERISA preemption. Accordingly, this new legislation is not intended to and should not affect the outcome of the Texas legislation either way.

Ms. GRANGER. Mr. Speaker, I thank the gentleman from Illinois for this clarification.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from the Virgin Islands (Ms. CHRISTIAN-GREEN), a physician of family medicine who has good advice for my colleagues.

(Ms. CHRISTIAN-GREEN asked and was given permission to revise and extend her remarks.)

Ms. CHRISTIAN-GREEN. Mr. Speaker, I rise to speak against H.R. 4250 and for the Patients' Bill of Rights. As has been pointed out over and over again by physicians and patients alike, what H.R. 4250, if passed, does is codify or write into law the very practices which time and time again have denied needed and appropriate medical care to us and our families.

On the issue of access to emergency care, the Ganske-Dingell bill assures that if patients reasonably think that they have an emergency illness, they can go to an emergency room and receive care that their plan will pay for. In the Republican bill, severe pain could not be used as a reason to access emergency care. That means if someone thinks they are having a heart attack, where often the only symptom is pain, they have to go to a phone and answer a laundry list of questions from some paper pusher maybe millions of miles away, before they can go to the hospital. And if it is not a typical pain, as often happens, that care would be denied.

If we pass H.R. 4250, severe pain, the most common symptom of a severe or serious medical condition, would not be a standard that a reasonable person could apply in going to an emergency room. Emergency care is just one more instance of where H.R. 4250 does not measure up to the demands of the American people.

The Ganske-Dingell bill is true managed care reform. It puts decisions back in the hands of the patient and their doctors and allows access to needed medical care. I urge its passage. Vote against H.R. 4250.

Mr. HASTERT. Mr. Speaker, what is the remaining time for both?

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Illinois (Mr. HASTERT) has 11½ minutes remaining, and the gentleman from Michigan (Mr. DINGELL) has 12½ minutes remaining.

Mr. HASTERT. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time and for his outstanding leadership on this issue.

Mr. Speaker, a mother of a 6-month-old child who was having trouble breathing called her HMO at 3:30 a.m. An HMO bureaucrat told the mother to go to the plan's network hospital 42

miles from her home. On the way to the hospital, the baby suffered cardiac arrest and later had both arms and legs amputated.

For the past 2 years, Democrats in Congress have been fighting to pass the Patients' Bill of Rights that could have protected this mother and child.

Last week, I met with a number of area residents in a restaurant in North Ridgeville who told story after story about coverage denied for emergency care and bureaucratic refusals of doctor-ordered tests to detect breast cancer.

But rather than protecting patients, the Republican leadership in Washington has introduced a proposal that protects millionaire insurance company executives.

A friend has diabetes or breast cancer. The Patients' Bill of Rights would guarantee access to a specialist. The insurance company Republican bill does not.

A grandfather experiences chest pains that may be a warning sign of a heart attack. The Patients' Bill of Rights would ensure he gets immediate attention at the nearest emergency room by requiring his HMO to cover this care. The insurance company Republican bill does not.

A child has been denied access to a pediatric specialist for asthma. The Patients' Bill of Rights would allow a parent to have access to an independent patient's appeal process. The insurance company Republican bill does not.

Under present law, the only people in America who enjoy complete immunity from lawsuits are HMOs and foreign diplomats. The Patients' Bill of Rights holds HMOs accountable in State court if they make a medical decision that harms the patient. The insurance company Republican bill does not.

Our bill provides real patient protections at a mere \$2 per patient per month, according to the Republican-appointed Congressional Budget Office. Our bill is supported by the Cancer Society and the National Breast Cancer Coalition.

Mr. Chairman, I urge my colleagues to defeat the Republican insurance company bill. Pass the Patients' Bill of Rights.

Mr. HASTERT. Mr. Speaker, I yield 45 seconds to the gentleman from California (Mr. MCKEON)

Mr. MCKEON. Mr. Speaker, I rise in support of this historic legislation that addresses the problem of the rising number of Americans who cannot afford health insurance. For the first time, we will be able to extend health care options to the 42 million people in our country who remain uninsured, while the Democratic substitute ignores the problem.

We know that most people without health insurance have one thing in common: They cannot afford health care. They are either self-employed or they work in small businesses that cannot afford to pay for health benefits. This bill solves this problem.

The Patient Protection Act creates association health plans to combat high costs of health care in our country. This new and unique solution allows small businesses and those that are self-employed to join together under the umbrella of trade and professional organizations to buy health insurance for themselves and their employees. Consequently, small businesses will have access to the same kind of health care options that big corporations currently enjoy.

Mr. Speaker, I urge my colleagues to support this bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), the chairman of our task force on this matter.

Mr. PALLONE. Mr. Speaker, I just wanted to mention, the Republicans keep talking about the number of uninsured in this country. I would point out that 4 years ago, when President Clinton tried to put forward a health care plan that would insure all Americans, they fought it vigorously. The fact that we have more Americans now without health insurance is their fault, because they would not allow the Clinton plan to come forward. So now the numbers of uninsured continue to grow.

Mr. Speaker, I just want to explain why the Democrats' bill is a vastly superior bill in terms of ensuring and expanding patients' access to physicians.

For example, the Patients' Bill of Rights ensures access to specialists. The Republican bill does not. Under the Democratic bill, if a patient has cancer, they could go directly to an oncologist. If their child has a specific problem, they could bring their child to whatever type of specialist their child might need. But under the Republican plan that child would still have to go to their primary physician for a referral, and there is no guarantee that they would get to see a specialist if they need one.

The differences between the two bills are more pronounced when it comes to seeing specialists outside of one's HMO. The Patients' Bill of Rights ensures that patients will be able to go outside their network, at no cost to them, if they need to see a specialist that their HMO does not have. Under the Republican bill, they are out of luck.

Another difference between the access each bill would provide is standing referrals. If a patient is fortunate enough to have an HMO that has the type of specialist they need when they get sick, under the Republican plan they still have to jump through hoops. The Republican plan does not allow patients who need care over a long period of time by a specialist to have standing referrals.

The Patients' Bill of Rights does not require patients to go back time and again to renew referrals. If a patient needs to see a specialist over a long period of time, they are guaranteed the right to see that doctor.

The Patients' Bill of Rights would also allow patients to designate that specialist as their primary care physician. Women could choose their OB/GYN as their primary physician. The Republican bill does not allow patients to designate their specialist as their primary care physician, nor their OB/GYN.

Another major difference is with the continuity of care issue. The Republican bill does not allow patients to continue to have the same doctor.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health and Environment of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Speaker, I rise in favor of H.R. 4250. I am proud of this bill. Whereas the Democratic bill focuses on patient protections, our bill focuses on basically the same patient protections and additionally places great emphasis on expanding health coverage and access for the insured and the uninsured, but both are accomplished without imposing burdensome government mandates.

Guaranteeing access to quality health care must always be a top priority. What good, in fact, are patient protections if access is not there? We do this through the creation of Health Marts and by broadening the role of the community health centers, so that for those who live in medically underserved areas it will be simpler to receive critical services.

The proposal creates community health organizations, which are basically managed care plans controlled by community health centers. It encourages more competition to lower prices for health consumers. Community health centers will have more money because they will have more private-paying patients using their facilities. As a result, these health centers will be able to provide care to even more uninsured people.

Of course, the bill before us includes important new patient protections. For months, people across the country have told Congress that they want to choose their own doctors. We listened to our constituents, and I am proud to say that through our bill, patients will now be guaranteed their choice of medical providers, contrary to what some others on the other side have said, and be better able to understand their health care policies.

Mr. Speaker, is it a surprise in fact to anyone that the other party is attacking a Republican bill? I think not. But we have been able, I think, to accomplish and to do what they did not even attempt during their many years of control of the United States House of Representatives.

Mr. Speaker, I say to my colleagues: Help us pass a bill which will help people now.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Speaker, Democrats initiated the effort in this Con-

gress to protect patients and their doctors from interference by insurance company bureaucrats. The Dingell-Ganske bill provides these protections and eliminates the complete exemption from accountability that many HMOs enjoy today under the Federal ERISA law.

The Republican bill, on the other hand, in an effort to preserve the insurance companies' shield of protection from accountability for their mistakes, creates a Federal bureaucracy in the Department of Labor and a complex appeals process diagramed here on this chart to my right. Look at this. An endless maze of bureaucratic nightmare created by the Republican bill.

In September of 1991, Phyllis Cannon was diagnosed with leukemia. On August 10 of 1992, her doctor sought approval from her HMO for a bone marrow treatment. Forty-three days later, her doctor pleaded for authorization and it was repeatedly denied.

□ 1145

By the time the HMO finally agreed, it was too late for the treatment and Phyllis Cannon died.

Could she have gone through this maze under the Republican bill and done any better? I think not. And if she had made it through the maze under the Republican bill, after her death she would have been entitled to only \$500 a day; under the Republican bill, a total recovery for her family of only \$20,000.

Is this what we call protecting patients? I think not. Vote against the Republican bill, vote for the Ganske-Dingell bill and prevent this kind of endless bureaucratic interference with medical decisions from happening to the patients of this country.

Mr. HASTERT. Mr. Speaker, I yield 45 seconds to the gentleman from Oregon (Mr. SMITH).

Mr. SMITH of Oregon. Mr. Speaker, H.R. 4250 moves us in the right direction. One of the ways it does this is by allowing community health centers to establish community health organizations. These would be health plans sponsored by health centers and the doctors themselves to give people the extra choice in their health care.

I used to serve on one of these boards and I recently visited these facilities in Michigan. Patients get first-class treatment and these centers do a great job, and this bill will increase the chance that these small hospitals can survive by allowing them to have the community health organizations. These provisions are going to help create the competition needed to make more regulation from Washington, D.C. unnecessary.

Support this bill.

Mr. HASTERT. Mr. Speaker, what is the remaining time?

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Illinois (Mr. HASTERT) has 8 minutes remaining and the gentleman from Michigan (Mr. DINGELL) has 6½ minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Speaker, we have included some special provisions in the Patient Protection Act that recognize the distinctive health care needs of patients, especially women and children. Medically, women are not just small men. Their bodies are different and their needs are different. And children are not little adults. They need specific and sometimes immediate care.

This bill provides women with direct access to their OB-GYN without preauthorization or referral by a primary care physician. It also lets parents get to a pediatrician directly.

As a former florist, I also know how costly it is to provide coverage to employees, and I know how frightening it is to an employee not to be sure that their health care will be there when they need it. And although the cost continues to skyrocket, my colleagues on the other side of the aisle continue to turn their backs on small businesses and the burden that these employers face.

The Patient Protection Act is the only proposal that addresses the growing health insurance crisis among the small business community, and the fact is the fastest growing segment of small business owners are businesswomen. These women-owned businesses are the businesses that we use every day: The woman who does our taxes, who cuts our hair, who runs the local day care center.

We have 8 million women-owned businesses that employ 18.5 million people, one out of every four U.S. workers, yet only 48 percent of the women-owned businesses with less than 25 employees can afford to offer health care insurance. We confront that problem by providing affordable health insurance to small businesses so they can provide peace of mind and security for their workers and their families.

I encourage each and every one of my colleagues to vote for this bill.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Florida (Mr. DEUTSCH).

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

Mr. DEUTSCH. Mr. Speaker, I rise against the proposed bill by the majority, which does not address any of the major needs the people of America are asking for in this proposal.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Pennsylvania (Mr. KLINK).

Mr. KLINK. Mr. Speaker, I thank the gentleman for yielding me this time and for his leadership on this issue.

Mr. Speaker, I am a pro-life Democrat, and that means, quite often, that the Democrats get mad at me because I am pro life, and the pro-life people get mad at me because I am a Democrat. But I can handle that.

I say that because whether someone gets to remain in a hospital when they need to, whether they get the drugs that their doctor wants, whether they

can see that specialist that can save their life, to me, is a life or death matter.

I have a lot of problems today standing on the floor of the House and sitting on the floor of the House listening to this debate after we went through this partial-birth abortion debate yesterday. Because to me, this is life and death. And if National Right to Life does not score this vote today, something is wrong. If the Catholic Church does not score this, something is wrong.

We cannot be pro life at conception and then abandon people once they are born, when their life is on the line, when they are fighting to get medical care that they need to live, and that is exactly what this debate is all about.

Let us compare the two bills. The Democratic Patients' Bill of Rights leaves medical decisions in the hands of doctors and parents. The Republican bill leaves the decision still in the hands of insurance companies.

The Dingell-Ganske bill of rights gives everyone the right to see a specialist. The Republican bill does not.

The Patients' Bill of Rights gives everyone the right to a real external appeals process. The Republican insurance company bill allows the insurance companies to make individuals pay for their appeal. So first an individual pays their premium, then they are denied coverage, then they pay the insurance company for an appeal.

The Patients' Bill of Rights that I am supporting gives everyone the right to hold their insurers accountable. If they are denied something and someone dies, if they lose a limb, then the decision-maker must be responsible for that decision. The Republican bill, the Insurance Company Protection Act, does not hold the decision-makers in the insurance companies accountable.

That is the difference between these bills. It is ridiculous. The American public wants us to change it. The Republicans are here today refusing to do that. I say we must vote today to protect life. We must vote for the Ganske-Dingell bill. We must vote also pro choice. Give patients and their doctors the choice, not the insurance companies.

Support Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Speaker, I thank the gentleman for yielding me this time, and very quickly let me tell my colleagues my experience and what I bring to the debate, I believe.

Unlike most Republicans, I was a trial lawyer. I made my living trying to enforce the rights of people, and at one time I had the largest medical malpractice verdict in the State of South Carolina. And I can tell my colleagues, my client would rather have had good health care than the money.

I know what I am talking about. I have sued doctors who are medically negligent, and it takes years and it is

no fun. The goal that I have today is to get people the treatment they need.

Let us talk about the lady who died of cancer. My mother died of cancer. Under this bill that I am supporting here, this is what would happen. An individual does not have to wait 43 days and get told no. The first thing that is a difference today is when a doctor calls up and says the patient needs cancer treatment, they are talking to a doctor, not a nurse. In their bill it can be a nurse. It does not have to be a doctor. So it is doctor-to-doctor. We require that now. No more clerks. The clerks are taken out of the mix and we replace it with a medical doctor.

I have lived in the real world, and sometimes doctors have an allegiance to the company and not to what is good for medicine. Under our bill, if it is an emergency situation, we take that case and send it to a panel of independent doctors who have no idea who the company is that is involved, has no idea the doctor who is treating the patient. They are just looking at the facts. Under our bill they have to give a decision in 6 days of whether or not the treatment is medically necessary. That lady will get the treatment.

If the patient is awarded at the independent review process, if there is a finding for the patient, our bill has a \$500 per-day penalty that kicks in. An individual can go to court right after that, get attorney fees, get the full benefit plus \$500 a day. And if the judge finds out the decision was made in bad faith to provide care, it is \$1,000 a day, up to \$250,000. This happens up front. And give me that any time, rather than a 4-year lawsuit.

If the HMO doctor says no, an individual can go get a lawyer, like myself, and go to court within 24 hours and get a temporary restraining order ordering the treatment be paid, by a judge in State or Federal court, and I can get my attorney fees. The lady does not die.

The penalties in this bill are to force people to make the right decision, not awards 4 years later. I will tell my colleagues about the \$500 claim in the next part of this debate and how our bill is better.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I rise in strong opposition to 4250, and let me tell the American people why. Privacy, privacy, privacy. Under the Republican bill our medical records are not safe. Any hospital, HMO or pharmacy that keeps our medical records can disclose them without our consent.

Imagine suffering from depression, paying for prescriptions out of our own pocket to keep our condition private. Under the Republican plan, a pharmacy could disclose the use of these prescriptions to an employer. Imagine a health care bureaucrat reviewing someone's family's medical history without their knowledge. Even more frightening is the very real threat that our medical

history could then be used against us to deny us employment or when we apply for a mortgage.

Anyone obtaining our medical records could distribute them to a divorce lawyer, to a newspaper or a political campaign. A business could investigate its employees to find out who has potential health problems. They could review our family's medical records to find out if any of our children were sick and how seriously they were, and the insurance company could then raise our premiums.

Wake up, America. Under the Republican plan the patient does not have to give their consent or be informed about the transfer of their medical records. This is an outrage of the highest order. This plan does not protect patients, it destroys the privacy that exists between doctors and patients. It should be called the Puncture of Privacy Act, and the American people should reject it and the Members of the House of Representatives should, too.

Vote for the Dingell-Ganske bill and reject H.R. 4250 on the grounds of privacy; if nothing else, on the grounds of privacy.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from California (Mr. FAZIO).

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to the last-minute Republican sham before us today. This is not the first time Republicans have buckled to pressure from their insurance industry contributors. It is not the first time under Speaker Gingrich Republicans have tried to pull one over on the American people by crafting something that sounds good in a 30-second campaign ad but does nothing fundamental to fix the problem. This is perhaps, however, the most cruel farce the Republicans have brought to this body since they took control.

For those on the other side of the aisle, who have already written the press releases and started patting themselves on the back and scheduled the air time for those 30-second spots, I ask them to look inside their souls and admit that what they have brought forth today will not end families' tragedies and needless human suffering.

If we pass this bill today, those managed care plans that do not operate as honorably as others will still go on putting profits over patients. Only now the blood will be on our hands. Under this bill, a health plan could still unhook a critically ill patient from the intensive care monitors and transfer the patient to an in-plan hospital. A health insurance bureaucrat could still withhold life-saving cancer treatment until it is too late and face no responsibility for that human life.

□ 1200

In my home State of California, State laws protecting patients who need prenatal care, well-child care, mammography screening, cervical cancer screening, diabetic supplies, and

nine other benefits would be overridden by this law, preempted.

This bill is a sham. Support the Dingell-Ganske bill, which doctors and patients support.

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Michigan (Mr. DINGELL) has 1 minute remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Massachusetts (Mr. OLVER).

Mr. OLVER. Mr. Speaker, I thank the gentleman for yielding.

What this people's House is doing today is the most cynical action I have seen them take in 7 years in Congress.

H.R. 4250, the so-called Patient Protection Act, is based on deception and a big lie. The only thing protected is the insurance industry. The best protection we could provide Americans would be to return decisions about their care to them and their doctors.

Instead, this bill drives the wedge between them and their doctor. The people of Massachusetts will be hurt by H.R. 4250 because it overrides patient protections already provided by State law. The mammography and cervical cancer screening for women, blood lead screening for children, bone marrow transplants for victims of leukemia, home health care for the aged, and a good many more are endangered under the Republican bill.

My constituents and the people of Massachusetts would be better off with no bill rather than 4250, the insurance industry protection act. But Massachusetts has a large insurance industry, and they will be happy with this Republican bill.

Support the Ganske-Dingell bill.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) has 4 minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. THOMAS), the distinguished chairman of the Subcommittee on Health of the Committee on Ways and Means.

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

Mr. THOMAS. Mr. Speaker, some of this debate has literally taken my breath away. If anyone listening to this debate wonders how in the world Republicans could get away with treating Americans the way we do, listening to the Democrats, I ask them to just look at the calendar. This is the pre-election warm-up.

Remember Medicare? Pre-election, Republicans were going to destroy Medicare. Well, the American people did not listen to them. We were returned as the majority. And as chairman of the Subcommittee on Health, we prepared a Medicare reform package that was passed in my subcommittee 11-0, no Democrats dissenting. Prior to the election, it would destroy Medicare. After the election, post-politics, everything is okay.

Today we are debating patient protections. Here we go again. It is pre-

election time. Have things changed out there in America? Of course they have. In 1988, health care inflation was 18½ percent. Today it is less than 5 percent. Why? To a very good extent, just 5 years ago, in 1993, about a majority of Americans, about half, got their health care from managed care. Today, if they get it from their employer, it is about 85 percent.

So health care markets have changed. Have there been distortions? Yes, there have been distortions. Do there need to be corrections? Of course there need to be corrections. But when we unite egos and politics, we get some pretty ugly offspring.

There have been Members who have taken the well and virtually every word they spoke about the Republican plan is absolutely, totally false. This headline that says "the bill would allow sale of patient data" in today's Washington Post is totally, absolutely false.

If my colleagues will turn to the bill, on page 260, the language is clear. If we read on, it says, "Limitation on Sale or Barter. Notwithstanding subsection (c) which is a limit which guarantees that State law is not overridden," it says, "no health care provider or health plan may as part of conducting health care operations sell or barter protected health information," period.

What was said to be contained in the Republican bill is absolutely, totally false. What we heard from my colleagues was that they want "medical necessity" defined in law. Who defines "medical necessity" in law? Bureaucrats, Health Care Financing Administration. We get specific items, medical necessity. That is cookbook medicine.

Who do we have define "medical necessity," for example, in an emergency room? Quote, page 144: "A prudent emergency medical professional." It is the medical professional there looking at the patient and their problem that determines what needs to be done, not some book drawn up by bureaucrats that lists what is and what is not medically necessary.

It has been said that it does not say "pain." What this bill says is that "a prudent lay person who possesses an average knowledge of health and medicine would determine such examinations to be necessary." Not itemized; across the board.

I heard my colleague the gentleman from North Carolina (Mrs. CLAYTON) say she cannot find the gag rule. I will tell her page 141, section 2706, says, "patient access to unrestricted medical advice."

So please understand, it is a pre-election season. But let me tell my colleagues something else. The Congressional Budget Office has laid out the numbers on the plan. Their plan increases premiums. Our plan reduces premiums.

Under the Republican plan, CBO, "lower medical malpractice costs would reduce Federal direct spending for Medicare and Medicaid by \$1.5 billion over 10 years."

We have heard them say ours is a sham and it drives prices up. It is simply not true. CBO says their plan will drive premiums up. CBO says our plan will drop premiums. Correct the marketplace and Federal costs. Vote "yes" on 4250.

Mr. DREIER. Mr. Speaker, I rise in support of H.R. 4520, the Patient Protection Act, because it upholds a patient's most fundamental right—the right to choose his/her own health care. As much as I believe that health insurance bureaucrats should not be able to decide what is best for patients, the federal government also should not be issuing onerous mandates and regulations that micromanage the care that patients receive. Instead, we should provide consumers with additional choices that may not be available from their employer-provided health care plan.

Many employees are frustrated because they are forced by their employer to join a health plan that does not offer the level of benefits or protections that they want. This occurs because the federal tax code prevents employees from making important decisions about their health care. Under a quirk in the federal tax code, employers receive a tax subsidy for providing health care to their employees, and since employers pay for the health care, there is an incentive to purchase a plan based on costs, not on level of benefits. To give employees the option to choose coverage with a higher level of benefits, the solution then is not to add another layer of mandates, but to alter the system so that employees can choose the health plan that is best for them.

To accomplish this goal, H.R. 4520 creates a system similar to the Federal Employees Health Benefits program known as HealthMarts which are private non-profit organizations that offer a variety of health benefits to small businesses and the self-insured. Employers pay a set fee to the HealthMart, and it provides a variety of health insurance options, including health maintenance organizations, paid provider organizations, and fee-for-service plans, to employees. With a HealthMart, the employee, not the employer, has the flexibility to choose the type of plan based on the level of benefits, protections and costs. HealthMarts eliminate the possibility that employees feel dissatisfied with the health coverage and empowers them to choose the best provider that meets their needs.

Unlike the Democrat substitute, H.R. 4520 actually addresses the 41 million Americans lacking access to affordable health insurance. Regrettably, many of these Americans are in families in which one member works in a job that does not provide health care coverage. Because they lack the purchasing power of large businesses, many small businesses often find the cost of providing coverage too prohibitive. H.R. 4520 gives small businesses and the self-insured the ability to bank together to obtain more affordable health care coverage. These Association Health Plans allow employers to join together through a trade association or their local Chamber of Commerce to broaden their risk pool and give them the same purchasing power as large corporations.

Mr. Speaker, H.R. 4520 provides an effective means to protect patients by offering them more choices. The Patient Protection Act restores accountability to health plans without raising premiums on the most vulnerable. It

will also reduce the number of uninsured through innovative reforms and the creation of health care "supermarkets" so that the average American can have more available choices. I would like to commend my colleagues who served on the Working Group on Health Care Quality for their tremendous efforts in bringing forth this responsible legislation, and I urge support of this measure.

Mr. KOLBE. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. This bill lays an excellent foundation and contains many important pro-patient provisions. This bill adapts for the changing health care market without the unintended consequences of increased costs, increased bureaucracies and an explosion of lawsuits. This bill expands access to health care for millions of Americans, makes health care more affordable for working families and small businesses, and holds health insurance companies accountable for their decisions about your care.

First, the Patient Protection Act allows individual's access to the best type of health care based on their and their families' needs. Women would have direct access, without having to go through a gatekeeper, to an ob/gyn as their primary care physician. It would also allow families to utilize a pediatrician for the health care of their children without the interference of an insurance gatekeeper.

The Patient Protection Act also makes it easier for individuals to learn more about what their health care plan covers and discuss options with our doctors to determine the best form of treatment. This bill requires health plans to cover emergency room care for conditions which a prudent layperson would view as requiring emergency treatment.

Second, the Patient Protection Act will make health more affordable for individuals. Most people without health insurance can not afford to pay for health benefits. They usually work in small businesses or are self-employed, but cannot afford to purchase health care insurance. This bill will make it affordable for small business owners to provide their employees with health insurance coverage.

Through the creation HealthMarts, and Community Health Centers Organizations, Association Health Plans, and Medical Savings Accounts, small business will have the same access to health insurance as large business, therefore creating a more affordable health insurance market for workers. Workers that currently are caught between being too poor for Medicaid, but not cannot afford health insurance.

And third, the Patient Protection Act makes health plans accountable for the health care services that are provided. Through the creation of an expedited review process—both internally and externally—individuals will be able to receive the care they need first, rather than being thrown into a long, drawn-out legal process controlled by trial lawyers, with no resolution until long after they've been harmed or killed. This is the only bill that truly relies on getting patients treated first in hospital rooms, rather than in the courtroom.

Mr. Speaker, I am pleased to vote in support H.R. 4250, the Patient Protection Act, and urge my colleagues to join us in protecting patients and guaranteeing choices without the heavy-hand of big government and provide patients, especially the 42 million un-insured, with access to affordable health care, when

they need it, where they need it, and with whom they need it.

Mr. MICA. Mr. Speaker, the question before us is whether we want to pay more and get less or correct some of the problems we have experienced with managed care.

It is true that the law and regulations have not kept up with changes in health care delivery.

It is also true that increasing costs are depriving millions of Americans affordable health care.

Unfortunately the Democrat plan will do three things we know will drive up costs. Their solution is more regulation, more bureaucracy, and more litigation.

In hearings I conducted on the President's fancy titled "Patients' Bill of Rights" for Federal employees, every administration official testified that his similar Executive Order would impose more paperwork at high cost without any benefit in coverage.

The Democrat plan proposes over 300 new mandates, thousands of new federal bureaucrats, and 59 new federal regulations.

The CBO estimates the Democrat plan will increase costs 4 percent. Add to that cost of living and they escalate health care premiums 7 percent per year.

The Democrat plan increases lawsuits which also increase health care costs. So what do you get? More costly regulation. More costly bureaucracy. More costly litigation.

I submit that's not what the patient, consumer or doctor ordered.

Mr. HILL. Mr. Speaker, recent polls show a growing desire on the part of Americans to address some concerns facing our health care system, including the number of uninsured working adults and dependents, the increased costs being passed to employees, and the lack of choice in health plans.

While Americans enjoy the best quality health care in the world, our system for delivering care often frustrates patients, providers and employers. Moreover, people are concerned that their health plan may not deliver the care they need when they are sick.

Today, we are addressing what the people want and deserve—a patients bill of rights. They do not want a trial lawyers right to work. H.R. 4250, the Patient Protection Act, which I am a cosponsor, will move ahead what I call the three A's—Accessibility, Affordability and Accountability.

The Patient Protection Act promotes accessibility by requiring basic protections to ensure high-quality health care coverage, promotes affordability by creating more choices and access to affordable health care coverage for all Americans, particularly the over 100,000 Montanans that are uninsured, and ensures accountability by holding insurance companies accountable so patients are guaranteed to receive high-quality care.

We achieve this by expanding the eligibility for medical savings accounts, allowing for the creation of new 'health marts' and permitting small employers to pool their risks with others, which will make health care become more affordable as well as more available.

The vast majority of the uninsured have one thing in common, they are either self-employed, work, or have a family member who works in a small business that cannot afford to pay for health benefits.

Furthermore, for those small businesses that are able to offer their employees cov-

erage, often they can only afford to offer one coverage option. In Montana, I constantly hear concerns with the affordability of health care. The Congressional Budget Office estimates that premiums would increase and the number of uninsured Americans will actually increase by 1.4 million if H.R. 3605 became law.

The question is who are we trying to help—patients, employees. We should look at who is opposed to H.R. 3605:

NFIB, Small Business Survival Committee, US Chamber, National Association of Wholesalers-Distributors, National Restaurant Association, the Coalition for Patient Choice, Citizens for a Sound Economy, NAM, National Retail Association among others.

Who supports the H.R. 3605—Trial Lawyers.

We address the very real concern patients in managed care plans have that their health plan won't provide the benefits they are entitled to if they get sick. We should do this by empowering patients, not trial lawyers. I want patients to get the care they are entitled to when they need it, not allow their heirs to sue for some large settlement after they die. The other proposal that I touched on earlier seen to concentrate on courtrooms over hospital rooms and would only increase health care costs by taking money away from care and putting it into the pockets of attorneys.

The Patient Protection Act will build upon what's good about our private health care system—without big government or more bureaucracy. It will make health insurance more accessible, affordable and accountable, while giving patients more choices.

Mr. HOBSON. Mr. Speaker, I rise today in strong support of the House Republican Health Care Proposal, the Patient Protection Act. I believe this bill strikes a good balance between protecting patient rights without the heavy hand of big government. I am excited about many of the large protections in this bill, like giving patients a better and quicker appeal process when the HMO denies their claim, lifting any gag orders on physicians to ensure that patients are better informed, and providing greater access to specialists for women and children. I believe this bill addresses the frustrating problems that upset so many people about their HMOs.

As many of you know, Representative TOM SAWYER and I wrote the Administrative Simplification language in the Health Insurance Portability and Accountability Act—Kassebaum-Kennedy. Administrative Simplification will reduce paper work, speed the processing and payment of medical transactions, and let physicians spend less time on paper work so they can do what they do best: treat patients. In putting together this legislation some estimated that Medicare could save \$60–90 billion per year if individual patients' financial records were kept from getting confused. Because of the confusion over individual Medicare financial records, the U.S. Department of Health and Human Services (HHS) which runs the Medicare program, often pays claims for beneficiaries that have outside supplemental insurance. After paying the claim, Medicare's only recourse to get its money back is to sue the insurance company, which it seldom does. The most obvious solution to this problem is a unique identifier for health care beneficiaries.

In these days of increased government scrutiny and tight federal budgets there are tremendous pressures on HHS to recover

these funds. Quite frankly, with these pressures on HHS I was afraid that they would rush to get in place a one-size fits all solution that might compromise patient privacy. To ensure that the system was not run by the bureaucrats at HHS and to guarantee public input, Congress instructed the National Committee on Vital and Health Statistics, an independent research organization, to hold hearings to gather information from private and public sector organizations to develop recommendations on establishing a way to keep individual patients' financial records from getting confused with one another.

After the hearings, the Committee will write a report that will be published in the Federal Register. Moreover, an amendment I introduced to the Patient Protection Act will guarantee that Congress reviews and approves any suggestions made by the Secretary of HHS on individual health care identifiers before they are implemented. This provides a built-in guarantee that Congress and the public will have a chance to comment on, participate in the development of, and ultimately approve any unique health care identifier before it goes into effect. Once again, this process insures public input and oversight to prevent another "Big-Brother" bureaucratic solution.

However, Administrative Simplification is not complete without the Confidentiality Standards proposed in the Patient Protection Act. Section 264 of Kassebaum-Kennedy states that if Congress does not pass legislation concerning the confidentiality of patient records within 3 years after the act goes into effect, then the Secretary of HHS will adopt her own final regulations. As a result, Congress is on a very tight time frame to propose and pass confidentiality legislation.

The Medical Record Confidentiality provisions in the Patient Protection Act provide the necessary safeguards required in Kassebaum-Kennedy. It allows patients access to their medical records in order to view, copy, and amend by addition; requires providers, plans and employers to develop safeguards to protect confidentiality of medical information; requires providers, plans and employers to disclose their confidentiality policies to patients, enrollees and employers; encourages health researchers to use non-identifiable information by preempting state laws in this defined area; allows providers and plans to use information within their network for certain defined purposes, including outcomes evaluation, health promotion, and utilization review.

The Medical Record Confidentiality provisions in the Patient Protection Act guarantee accurate records and prevent unlawful use of one's medical records.

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to this last minute Republican sham before us today. Mr. Speaker, this is not the first time the Republicans have buckled to pressure from their insurance industry contributors.

It is not the first time under Speaker GINGRICH, Republicans have tried to pull one over on the American people by crafting something that sounds good in a 30-second campaign ad, but does nothing—fundamental—to fix the problem.

But this is perhaps the most cruel farce the Republicans have brought to this body since they took control.

For those on the other side of the aisle who have already written the press releases patting

yourselves on the back—and scheduled the air time for those 30-second spots—I say look inside your souls and admit that what you have brought forth today will not end families' tragedies and needless human suffering.

My colleagues, if you pass this bill today, those managed care plans that do not operate as honorably as others will still go on putting profits over patients. Only now, the blood will be on your hands.

Under this bill, a health plan could still unhook a critically ill patient from the intensive care monitors and transfer the patient to an "in-plan" hospital.

A health insurance bureaucrat could still withhold life-saving cancer treatment until it is too late—and face no responsibility for that human life.

In my home state of California, state laws protecting patients who need prenatal care, well child care, mammography screening, cervical cancer screening, and diabetic supplies and 9 other benefits—overridden—preempted by Fed law would be moot.

Put this bill to the test before you vote: Does it provide adequate access to medical specialists? No; Emergency services for severe chest pain? No; Proper care for women who have mastectomies? No; Patient recourse when needed care is denied? No.

Right down the line, the Republican bill is a failure and a cruel hoax.

If you pass this bill today, you will go on hearing the stories from your constituents who were denied care they paid for in their health plans.

If you fail to join Dr. GANSKE and Congressman DINGELL—you will guarantee that life or death decisions are made by health insurance bureaucrats, not doctors. Instead, you will be complicit in people's pain.

You are playing with people's lives here today. Don't choose a placebo over a real cure.

Vote NO on this last minute farce we have before us today. Support Dingell-Ganske which is supported by doctors and patients.

Mr. OXLEY. Mr. Speaker, I rise today in strong support of the Patient Protection Act. Since Republicans took control of Congress in 1995 we have worked diligently to pass health care reform legislation that gives Americans greater choices, makes health care more affordable, and improves the quality of the health care they receive. I believe this legislation adds to the long list of legislative accomplishments that Republicans have achieved in this arena.

Allow me to expand on some of these accomplishments. First, through passage of comprehensive Food and Drug Administration reform, the Republican Congress helped expedite the development and delivery of new healthcare technology. As a result of these reforms, which streamlined the FDA bureaucracy and cut government red tape, we will help save the lives of millions of Americans over the coming years.

Second, while many initially criticized our efforts at passing much needed Medicare reform, we succeeded in passing a bipartisan reform package designed to save this critical program until 2007 while establishing a bipartisan panel to consider options that will ensure Medicare's long-term financial health. This responsible package of reforms also included provisions to give Medicare beneficiaries greater choice, crack down on fraud and

abuse, and grant beneficiaries new preventative health benefits. For the 34 million seniors that rely on Medicare for their health care needs I was pleased to support this valuable legislation.

Finally, any discussion of major health care accomplishments would not be complete without highlighting the 1996 Health Care Portability and Accountability Act. This legislation was a common-sense, market based solution to one of America's most difficult health care problems—namely the portability of health insurance. By guaranteeing that people can go from one employer to another without facing pre-existing condition restrictions or being denied coverage by a new employer's insurance plan this legislation ended the problem of job-lock by allowing workers to switch jobs without the fear of losing their insurance coverage.

Today, in our continuing efforts to strengthen the health care American's receive, we will consider legislation that address many of the concerns patients all over our country have with the health care marketplace. This legislation focuses on making health care more affordable for working families and small businesses, while holding insurance companies accountable for their decisions, and expanding access to health care for millions of Americans. I commend Congressman HASTERT for his fine work with the House Republican Working Group on Health Care Quality in bringing this legislation to the House floor. I am pleased with the outcome of the working group that I feel builds on and strengthens our previous accomplishments.

While many have advocated reforms that would significantly increase both costs and expand government bureaucracies, I support the Republican Task Force legislation because it protects patients and expands access to health care without damaging the free market health care system we enjoy today. Mr. Speaker I urge my fellow colleagues to support this much needed legislation that ensures that the health insurance Americans receive is accessible, affordable, and accountable without crippling the free market's ability to hold down health care prices.

Mr. GILMAN. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. As managed care has continued to grow as the major system of health care delivery in this country, we are increasingly aware of incidents where patients have suffered serious injury or even death because an HMO or other managed care plans denied a treatment that was necessary to protect the patient. An emphasis on cost control over the quality of care has prevented health care professionals from acting in the best interest of the patient. While looking for ways to control the cost of health care, we must also ensure that people have access to quality health care services when the need it.

The legislation before us today attempts to make significant changes in the managed care industry. H.R. 4250 guarantees access to emergency room care by applying a "prudent layperson" standard of what constitutes an emergency, additionally, this bill will allow women direct access to their ob/gyn and children to their pediatrician. This access will prevent patients from having to be referred to these type of specialists by their primary provider.

This bill would also provide for an independent appeal process. If a patient is unhappy

with the initial decision, he or she can ask for an independent internal review within 30 days of the decision. If that decision is unsatisfactory, they can appeal for an independent external review by an independent contracted physician. If after these two appeals, they are still unhappy, the patient can take the HMO to court and sue for damages up to \$250,000.

The Patient Protection Act would require all insurance providers to provide detailed information to their customers including patients' responsibilities, the number of appeals made and granted as well as other plan information. This provision is intended to arm the consumer with all of the necessary information up front so that future appeals and litigation become unnecessary.

Although this bill provides a great number of HMO reform provisions, there are still a few items which need to be addressed and amended during the House-Senate conference. I urge the conferees to consider changes to this legislation which will provide greater patient protection and strengthen HMO liability.

Accordingly, I am pleased to support H.R. 4250, the Patient Protection Act.

Mr. UPTON. Mr. Speaker, I rise to express my strong support for the Patient Protection Act. Before I review the reasons that I support this legislation and will work hard for its enactment, I want to take this opportunity to single out two of my colleagues without whom this bill which will do so much to ensure quality of care would not be before us today. First, I want to thank CHARLIE NORWOOD, who saw early-on the need for strong patient protections. He introduced the Patient Access to Responsible Care Act and used this legislation as a vehicle to educate all of us to the need for reforms. Second, I want to express my deep regard for the leadership, patience, and effort that DENNY HASTERT has shown in the development of the Patient Protection Act, the legislation we are considering today. He had a Herculean task, and he did it with skill and grace.

I am proud to be counted as a cosponsor of the Patient Protection Act. This legislation will ensure that our nation's health care system is patient-centered, not profit-centered and that no one, no insurance clerk or green eyeshade worrying about a fat profit, stands between the patient and the physician when potentially life and death health care decisions are being made.

There are some who continue to argue that patient protection legislation is not needed—that the market will work over time to ensure patients have access to care when they need it and receive high quality care. That has not been my experience at all. Rarely a day goes by that I don't hear or read in my constituent mail of serious problems that individuals or their families are having with their managed care plans. Just yesterday, for example, I received a report of a Michigan woman who was experiencing severe pain from an ovarian cyst. She went to the nearest hospital, but her managed care plan would not cover her care at that facility. Instead, a plan clerk directed her to another, more distant facility. Unfortunately, that facility was affected by a massive power outage in the Detroit area and could not see her promptly. She requested permission to return to the first hospital, but was denied. By the time she was finally treated, she had a massive internal infection from the ruptured

cyst. Her doctor said she was lucky to be alive.

We need to stop this rising drum-beat of stories of patients being denied appropriate care by their health plans, and the Patient Protection Act will do this. Had the Patient Protection Act been in place, for example, this woman could have sought and received care at the nearest emergency room rather than having to seek prior authorization and go to another, more distant facility.

Perhaps the single most important patient protection in this legislation is the right it will give patients to a timely review of plan determinations with which they disagree. Patients may seek an internal and then an independent external review, both of which must be conducted by physicians who are trained in the provision of the treatment under review. The patient may then go to court to enforce the ruling of the external review organization that a service should be provided or covered. If the court upholds the finding of the independent expert external reviewer, which is highly likely, the plan is subject to fines of \$500 per day up to a total of \$250,000.

I think the internal/external review appeal process in this legislation is actually more likely to hold plans' feet to the fire for their decisions and ensure appropriate access to care than would be the case if patients could simply go to court and sue their plans or employers. While the penalties leveled in state torts might be greater in some cases, such cases can drag on for years and the outcome is never certain for individuals. And the uncertain, uncapped liability exposure to which employers could be subject under the state court suit option could lead to employers terminating plans and add significantly to the number of individuals and families with no health care coverage.

In closing, I strongly urge my colleagues to join me in voting today for the Patient Protection Act. It ensures that our Nation's health care system is patient-centered, not profit-centered. It ensures that medical decisions are made by patients and their physicians with the well-being of the patient being the first consideration.

Mr. GEJDENSON. Mr. Speaker, for the past few months, my democratic colleagues and I have demanded that Republicans bring HMO reform to the floor. And now, what do we get. Barely 2 hours to debate a bill that was introduced just last week and has had no hearings, no mark-up, no public discussion of any kind.

The Republican bill will do little to fix the problems with the HMO system. The Republican bill does not allow direct access to specialty care. If you have heart disease, you must still go through a primary care doctor before seeing a cardiologist. If you have cancer, you must go through your primary care physician before you can see an oncologist. The Patient's Bill of Rights, which I support, guarantees patients access to specialists without going through a gatekeeper.

The Republican bill will not require HMOs to pay for emergency room visits if a patient has severe pain, but does not have a serious medical problem. Parents who take a child to the emergency room when they complain about pains will not know if their insurance company will cover the visit. This bill expects parents to be doctors and penalizes them for taking prudent steps. The Republican bill will not prohibit gag orders on doctors in group practice. It will

not prevent plans from arbitrarily limiting medically-necessary services. It will not allow patients to sue HMOs for decisions that adversely affect them.

The Patient's Bill of Rights will fully address all of these problems. Access to medically needed care, including access to emergency rooms and specialists, is a fundamental element of the Patient's Bill of Rights. This bill will ban all gag rules on physicians. This bill will end the current practice of HMO's offering financial incentives to withhold necessary care. This bill will guarantee timely internal appeals, as well as an independent external appeals when plans deny care. Finally, the Patient's Bill of Rights holds plans legally accountable for decisions that lead to serious injury or death. People need real ways to hold HMOs responsible. In too many instances, courts are the only advocate that patients have in their battles with multi-billion dollar companies.

It is time for true HMO reform. We all know people who have been injured by HMOs. Just this week, a woman from my district got in touch with me and relayed what is probably an all too common occurrence:

This Monday, she had a hysterectomy. On Tuesday, 24 hours later, her HMO wanted her out of the hospital even though she was feverish and had medical staples holding her abdomen together. Her doctor demanded that her HMO allow her to stay in the hospital at least one more day. Her HMO relented because of her fever but after the fever broke on Wednesday, she was forced out. She was sent home, still weak and groggy and not even close to recovery. How is she supposed to get well? This is not what she paid for when she paid her premium.

Republicans claim that their bill will stop this type of abuse, but it won't. Their bill has no guarantee that doctors, not HMOs will determine what amount of time is needed to recover from major surgery. The Patient's Bill of Rights will make sure that doctors and patients, not HMO plan administrators, decide when it's time to go home.

Under the Republican bill, what can patients and their families do when they are denied care? Other than jump through some hoops—not much! First, patients will have to prove during the internal appeal that their care is medically necessary. In the Republican bill, the definition of medically necessary is determined by the health plan—not by decades of medical experience, not by doctors there in the examination room with the patient. Then, if the internal appeals process doesn't work, the Republican bill will force patients to pay to have an independent review of their claim.

This is outrageous for two reasons. First, charging a fee is designed to discourage people from using this recourse. Second, HMOs will only be held accountable for failing to follow the provisions of their plan. As a result, as long as the HMO follows its own rules, patients receiving nothing from the external appeals provision even if their health is compromised.

In the Patient's Bill of Rights, the definition of medically necessary is uniform for all—a definition drafted by doctors, not HMOs. The Patient's Bill of Rights not only has internal and external appeals—both free of charge—but also sets up an Ombudsman program to assist consumers in understanding their health insurance options and filing appeals and grievances with their HMOs.

The Republicans also seem to think that it's a good thing that their bill will deny patients access to the court system when their care is denied. Somehow, Republicans believe that the health insurance industry, which makes \$952 billion a year, needs protection from lawsuits. When one of your family members dies because an HMO denies access to care, the Republican bill gives you nowhere to turn. No other industry enjoys such a powerful, congressionally-mandated shield from liability for their actions. It's time to remove that protection for health plans and focus on granting more protections for patients.

If the bill in and of itself isn't bad enough, the proponents of this sham have added totally unrelated provisions which further threaten the quality of health care for all Americans. Once again, Republicans are threatening Medicare by expanding so-called Medical Savings Accounts. Remember these? They will allow healthy senior citizens to pull out of Medicare leaving it with only the poorest, sickest older Americans. This is bad medical policy and even worse fiscal policy. Other provisions preempt state laws and jeopardize patient privacy.

We must create a better system for everyone who gives or receives health care in this country. The Republican plan will do nothing to help our Nation's patients. For real reform, we must pass the Patient's Bill of Rights.

Mr. NUSSLE. Mr. Speaker, I rise today in support of the Patient Protection Act. I support this bill because it establishes Association Health Plans and Health Marts as new ways to provide health insurance to workers, many of whom work for small businesses which cannot currently afford to provide health insurance to their employees. Individuals who work for small businesses are the people most likely to be without health insurance. I also applaud the increased care options this bill provides for individuals dissatisfied with the choice of doctors provided by their health plan.

The national debate on health care has been focused almost exclusively on the care provided by HMOs. Providing appeals processes and other recourses for patients in HMOs are important and appropriate steps for Congress to take in order to ensure quality care. However, in all the talk over giving recourse and options to individuals with HMO coverage, both bills have overlooked the fact that the Patient Protection Act and the Kennedy-Dingell bill primarily address the fears and complaints of Americans who are fortunate enough to have real access to health care and a menu of health care options.

For many Iowans, access to health care doesn't mean the ability to see a specialist on demand. There are few specialists in Grundy Center, Iowa. People in Iowa's Second District have to load a family member into the car and drive miles and miles to the nearest doctor, clinic or emergency room. A patient bill of rights means little or nothing to people whose only choice of a hospital or clinic is 40 or 50 miles away. And miles mean minutes, which are crucial in the event of an emergency. Improving access to health care in Iowa means recruiting more doctors so that people will have shorter drives, and maybe a choice of where to go.

I am disappointed that neither proposal the House is considering today contains any initiatives to address the shortage of doctors in rural America. Twenty-five percent of the

American population lives in rural areas. By the federal government's own count, almost 2,500 counties in our nation lack adequate medical care. Last year, Congress acted to make this shortage worse by creating a program to pay hospitals to train fewer doctors. What we need in Iowa are more doctors. The resources being spent to reduce the number of physicians would be better spent providing incentives to encourage doctors to locate in areas with inadequate access to health care.

The Patient Protection Act provides valuable protections and new health care options to many individuals, and I support those goals. However, I hope that today's vote on the Patient Protection Act is the beginning of the debate on improving access to health care and not the end. This debate is essential for people in Iowa's Second District and one in which I intend to participate vigorously.

Thank you, Mr. Speaker.

Mr. CRANE. Mr. Speaker, today, this House has an opportunity to improve the health care system for millions of Americans. Like everyone, I want a health care system that is more accessible, more affordable and more accountable. With that goal in mind, I will cast my vote for H.R. 4250, the Patient Protection Act.

It is not a perfect piece of legislation and while there are provisions I think could be improved, there are also other provisions I have long supported. I am particularly pleased with the expansion of medical savings accounts, the creation of association health plans, medical malpractice reform and improving the patient appeals process without increasing the involvement of trial lawyers. In response to the concerns we have heard from our constituents, the bill prohibits gag rules, allows women direct access to gynecological and obstetrical care and allow parents to choose a pediatrician as their child's primary care provider without having to get a referral from a health plan.

This legislation will not only improve health care for the currently insured, we expect it to also make insurance more affordable to the 41 million uninsured Americans, including the 1.3 million uninsured in my state of Illinois.

As a member of the Ways and Means Health Subcommittee, I have taken an active interest in the many innovative ideas in health care. The Patient Protection Act represents the only choice for those of us who do not want a heavy-handed, big-government takeover of our health care system. The American people overwhelmingly rejected that proposal and made it clear they want quick access to the best medical care in the world at an affordable price. The Patient Protection Act moves us in that direction and I would urge my colleagues to vote in support of it.

Ms. BROWN of Florida. Mr. Speaker, I represent the 3rd District of Florida. And, senior citizens in my district which ranges from Jacksonville to Orlando have suffered at the hands of HMO providers day-after-day. They are urged to sign up for health coverage plans, and these HMOs only give them cheap gifts and inadequate health coverage.

Because I have hosted numerous town hall meetings on health care for senior citizens, I have been able to hear their stories and provide assistance when their insurance providers have failed to deliver. An 81-year-old man, who after his HMO was sold had to replace his regular hypertension drug with a lower-cost one. Within days his blood pressure sky-

rocketed. He switched to an HMO that covered his drug, but then the new plan changed its coverage too. Unable to pay for the drug, he went on TV as a cry for help and a local physician with compassion gave him the medication for free. Health care is such a crucial part of our lives, I believe every effort should be made to protect senior citizens and the working poor. It is our responsibility to protect and pass legislation that will protect the rights of our constituents. More importantly, we are charged with ensuring that our nation has access to quality health care at an affordable cost. There is nothing more heart wrenching, than talking with someone who desperately needs medical care and their insurance company will not cover the life-saving medical treatment or reimburse patients for much needed medicine. In another case, a baby girl was diagnosed with a hole in her heart. Chances were good that she would need surgery to fix the defect if it did not close on its own. Her mother switched HMOs for better coverage; however, the new insurance company would not cover the procedure because her daughter's heart defect was a pre-existing condition. The HMO had a 2 year limit on pre-existing conditions and would not pay for the little girl's operation. Thanks to a special state program in Florida the little girl was able to receive care. We need to hold HMOs accountable for their actions and how they treat people. That is why, I urge my colleagues to oppose the Patient Protection Act (H.R. 4250) and support the Patient Bill of Rights (H.R. 3605). H.R. 3605 is the right choice, it puts patients before profits and medical decisions are given back to doctors and nurses. This bill also holds HMOs responsible for decisions when they withhold or limit care to patients.

The challenges of quality health care will require our nation to overcome the barriers of ever-increasing medical cost and recognize the needs of our nation. In a society where technology is progressing at the speed of light, why is it so difficult for us to make the right decision for the American people?

We need to treat quality health care as a right versus a luxury for a privileged few.

Mrs. MINK of Hawaii. Mr. Speaker, I rise in opposition to H.R. 4250, the Patient Protection Act of 1998, because it falls short of addressing America's true health care issues. The essence of the health care debate is threefold: access to health care; patient protections; and patient rights. The Democratic substitute, the Patients' Bill of Rights, would address all three of these issues. This bill, the so called Patient Protection Act, does not.

First, Americans, despite being insured, are tired of having to fight every step of the way for care they are entitled to. Americans want access to care. The Patient Protection Act would not alleviate many of the existing barriers to care identified as priorities. For example:

The Patient Protection Act would not provide direct access to specialists. It does not guarantee women direct access to their OBGYN nor would it provide parents direct access to pediatricians for their children.

The Patient Protection Act would not insure a patient can continue to see the same doctor through a course of a treatment or a pregnancy if that doctor leaves the network.

The Patient Protection Act would not insure that a patient can get the prescription drug chosen by the physician, not the HMO.

The Patient Protection Act would not allow patients with ongoing conditions to have standing referrals to specialists.

The Patient Protection Act would not ensure that patients are allowed to see an outside specialist at no additional cost when specialists in their plan are unable to meet their needs.

The Patients Bill of Rights will provide all of these.

Second, patients should have the right to hold managed care administrators accountable for their decisions when it influences the care that is provided.

The Patient Protection Act does not hold managed care plans accountable when decisions to deny or delay care results in injury or death. It does not provide patients the right to sue HMOs when they are denied needed health care nor does it provide a true external independent appeals process. In fact, the Patient Protection Act reduces accountability by placing an arbitrary cap on medical malpractice awards.

In addition, the Patient Protection Act does not ensure that doctors and nurses can report quality problems without retaliation from HMO's, Insurance companies and hospitals. The Patient Protection Act would not prevent health care professionals from being financially rewarded for limiting a patient's care. Patients deserve care from health care professionals who are not rewarded for providing less care.

The Patients' Bill of Rights would provide these protections and true accountability.

Finally, patients deserve basic health care protections. After preaching a mantra of returning power to the states since taking control of Congress four years ago, Republicans take a hypocritical u-turn and pre-empt carefully constructed state health care protections. The Patients' Protection Act will allow "Healthmarts" to pick and choose the services covered under the plan, ignoring state mandated minimum benefit requirements. It would also eliminate state regulations enacted to insure solvency and protect against fraud and abuse.

The Patients' Bill of Rights would not pre-empt state mandated care nor would it eliminate solvency and fraud and abuse protections.

In closing, Americans deserve health care from qualified physicians who are not influenced by health care plan administrators. Americans deserve the right to take their health plans to court if they are denied care. America wants real managed care reform. The Patient Protection Act is not real managed care reform. This is a facade and a sham designed to provide political cover for Republican leadership who have argued that managed care reform is not necessary.

Do not judge a bill by its title. The Republican Patient Protection Act is a facade. It's meager "protections" do not address the real issues we are faced with. The Patients' Bill of Rights on the other hand is a comprehensive and revolutionary bill providing substantive reform.

America understands the difficulties involved with obtaining health care. The Patients' Bill of Rights provides solutions. The Patient Protection Act creates more problems.

Mr. TURNER. Mr. Speaker, it has been suggested that the Republican bill provides better protection for patients. I submit to my col-

leagues that the Republican bill provides fewer protections for patients than exist in current law in most of our States.

I come from Texas. The Texas Legislature passed patient protection legislation in 1997, fully intending that all HMOs be covered by the protections of State law.

The Republicans submit a bill today that would control patient protections at the Federal level. It would set forth a series of rules that are far inferior to those in the Democratic alternative.

Under the Republic proposal, if the HMO denied coverage, the only remedy, if an individual was enrolled in a self-insured plan, would be to go to Federal Court. And once the individual gets there, he or she would have no genuine recourse.

In 1991, Phyllis Cannon was diagnosed with leukemia. She appealed to her HMO for a bone marrow transplant. The HMO refused. For over 40 days the HMO refused coverage. Due to a denial of medical treatment, about a month after that Ms. Cannon died.

The court ruled that under ERISA, she had no recovery. Under the Republican bill today, her estate would be entitled to \$20,000—a small price for a life. Under the Republican bill, the penalty would be \$500 per day. This represents a much cheaper alternative for an HMO than providing the treatment that should have been provided to Phyllis Cannon.

I submit to my colleagues that all Members of this House needs to look at what their State has done to protect patients because a vote for the Republican bill amounts to rolling back the protections that most of our State have already provided for patients under the law. In every place in this country, protecting patients enrolled in HMOs has been a bipartisan effort. Only in Washington is patient protection partisan.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DINGELL

Mr. DINGELL. Mr. Speaker, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 in the Nature of a Substitute Offered by Mr. DINGELL:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patients' Bill of Rights Act of 1998".

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

Subtitle A—Access to Care

- Sec. 101. Access to emergency care.
- Sec. 102. Offering of choice of coverage options under group health plans.
- Sec. 103. Choice of providers.
- Sec. 104. Access to specialty care.
- Sec. 105. Continuity of care.
- Sec. 106. Coverage for individuals participating in approved clinical trials.
- Sec. 107. Access to needed prescription drugs.
- Sec. 108. Adequacy of provider network.
- Sec. 109. Nondiscrimination in delivery of services.

Subtitle B—Quality Assurance

- Sec. 111. Internal quality assurance program.

- Sec. 112. Collection of standardized data.
- Sec. 113. Process for selection of providers.
- Sec. 114. Drug utilization program.
- Sec. 115. Standards for utilization review activities.
- Sec. 116. Health Care Quality Advisory Board.

Subtitle C—Patient Information

- Sec. 121. Patient information.
- Sec. 122. Protection of patient confidentiality.
- Sec. 123. Health insurance ombudsmen.

Subtitle D—Grievance and Appeals Procedures

- Sec. 131. Establishment of grievance process.
- Sec. 132. Internal appeals of adverse determinations.
- Sec. 133. External appeals of adverse determinations.

Subtitle E—Protecting the Doctor-Patient Relationship

- Sec. 141. Prohibition of interference with certain medical communications.
- Sec. 142. Prohibition against transfer of indemnification or improper incentive arrangements.
- Sec. 143. Additional rules regarding participation of health care professionals.

Sec. 144. Protection for patient advocacy.

Subtitle F—Promoting Good Medical Practice

- Sec. 151. Promoting good medical practice.
- Sec. 152. Standards relating to benefits for certain breast cancer treatment.
- Sec. 153. Standards relating to benefits for reconstructive breast surgery.

Subtitle G—Definitions

- Sec. 191. Definitions.
- Sec. 192. Preemption; State flexibility; construction.
- Sec. 193. Regulations.

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

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

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

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

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

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

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

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

TITLE VI—REVENUE PROVISIONS

- Sec. 601. Estate tax technical correction.
- Sec. 602. Treatment of certain deductible liquidating distributions of regulated investment companies and real estate investment trusts.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS**Subtitle A—Access to Care****SEC. 101. ACCESS TO EMERGENCY CARE.****(a) COVERAGE OF EMERGENCY SERVICES.—**

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

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

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

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

(i) the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider, and

(ii) the plan or issuer pays an amount that is not less than the amount paid to a participating health care provider for the same services; and

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

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

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

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

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), or, in the absence of guidelines

under such section, such guidelines as the Secretary shall establish to carry out this subsection.

SEC. 102. OFFERING OF CHOICE OF COVERAGE OPTIONS UNDER GROUP HEALTH PLANS.**(a) REQUIREMENT.—**

(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (or health insurance coverage offered by a health insurance issuer in connection with a group health plan) provides benefits only through participating health care providers, the plan or issuer shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan or coverage and at such other times as the plan or issuer offers the participant a choice of coverage options.

(2) EXCEPTION.—Paragraph (1) shall not apply with respect to a participant in a group health plan if the plan offers the participant—

(A) a choice of health insurance coverage through more than one health insurance issuer; or

(B) two or more coverage options that differ significantly with respect to the use of participating health care providers or the networks of such providers that are used.

(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term “point-of-service coverage” means, with respect to benefits covered under a group health plan or health insurance issuer, coverage of such benefits when provided by a nonparticipating health care provider. Such coverage need not include coverage of providers that the plan or issuer excludes because of fraud, quality, or similar reasons.

(c) CONSTRUCTION.—Nothing in this section shall be construed—

(1) as requiring coverage for benefits for a particular type of health care provider;

(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options; or

(3) as preventing a group health plan or health insurance issuer from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option.

(d) NO REQUIREMENT FOR GUARANTEED AVAILABILITY.—If a health insurance issuer offers health insurance coverage that includes point-of-service coverage with respect to an employer solely in order to meet the requirement of subsection (a), nothing in section 2711(a)(1)(A) of the Public Health Service Act shall be construed as requiring the offering of such coverage with respect to another employer.

SEC. 103. CHOICE OF PROVIDERS.

(a) PRIMARY CARE.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee to receive primary care from any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

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

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer

clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating providers with respect to such care.

SEC. 104. ACCESS TO SPECIALTY CARE.**(a) OBSTETRICAL AND GYNECOLOGICAL CARE.—**

(1) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care provider—

(A) the plan or issuer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual's primary care provider; and

(B) if such an individual has not designated such a provider as a primary care provider, the plan or issuer—

(i) may not require authorization or a referral by the individual's primary care provider or otherwise for coverage of routine gynecological care (such as preventive women's health examinations) and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(ii) may treat the ordering of other gynecological care by such a participating physician as the authorization of the primary care provider with respect to such care under the plan or coverage.

(2) CONSTRUCTION.—Nothing in paragraph (1)(B)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

(b) SPECIALTY CARE.—

(1) SPECIALTY CARE FOR COVERED SERVICES.—

(A) IN GENERAL.—If—

(i) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(ii) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(iii) benefits for such treatment are provided under the plan or coverage, the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(B) SPECIALIST DEFINED.—For purposes of this subsection, the term “specialist” means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(C) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under subparagraph (A) be—

(i) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

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

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(D) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(E) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to subparagraph (A), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(2) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

(A) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in subparagraph (C)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(B) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in paragraph (1)(C)(i)).

(C) ONGOING SPECIAL CONDITION DEFINED.—In this paragraph, the term "special condition" means a condition or disease that—

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

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

(D) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

(3) STANDING REFERRALS.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist.

(B) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

SEC. 105. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage,

and a health care provider is terminated (as defined in paragraph (3)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing a course of treatment from the provider at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination, and

(B) subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period (provided under subsection (b)).

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

(3) TERMINATION.—In this section, the term "terminated" includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer

may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the provider agreeing to the following terms and conditions:

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

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

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

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

SEC. 106. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

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

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

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

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

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

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

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

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

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

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

(2) Either—

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

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

(C) **PAYMENT.**—

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

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

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

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

(d) **APPROVED CLINICAL TRIAL DEFINED.**—

(1) **IN GENERAL.**—In this section, the term "approved clinical trial" means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

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

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

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

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

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

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

SEC. 107. ACCESS TO NEEDED PRESCRIPTION DRUGS.

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

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

(2) disclose to providers and, disclose upon request under section 121(c)(6) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 115, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

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

(1) **IN GENERAL.**—A group health plan (or health insurance coverage offered in connection with such a plan) that provides any coverage of prescription drugs or medical devices shall not deny coverage of such a drug

or device on the basis that the use is investigational, if the use—

(A) in the case of a prescription drug—

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

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

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

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

SEC. 108. ADEQUACY OF PROVIDER NETWORK.

(a) **IN GENERAL.**—Each group health plan, and each health insurance issuer offering health insurance coverage, that provides benefits, in whole or in part, through participating health care providers shall have (in relation to the coverage) a sufficient number, distribution, and variety of qualified participating health care providers to ensure that all covered health care services, including specialty services, will be available and accessible in a timely manner to all participants, beneficiaries, and enrollees under the plan or coverage.

(b) **TREATMENT OF CERTAIN PROVIDERS.**—The qualified health care providers under subsection (a) may include Federally qualified health centers, rural health clinics, migrant health centers, and other essential community providers located in the service area of the plan or issuer and shall include such providers if necessary to meet the standards established to carry out such subsection.

SEC. 109. NONDISCRIMINATION IN DELIVERY OF SERVICES.

(a) **APPLICATION TO DELIVERY OF SERVICES.**—Subject to subsection (b), a group health plan, and health insurance issuer in relation to health insurance coverage, may not discriminate against a participant, beneficiary, or enrollee in the delivery of health care services consistent with the benefits covered under the plan or coverage or as required by law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

(b) **CONSTRUCTION.**—Nothing in subsection (a) shall be construed as relating to the eligibility to be covered, or the offering (or guaranteeing the offer) of coverage, under a plan or health insurance coverage, the application of any pre-existing condition exclusion consistent with applicable law, or premiums charged under such plan or coverage.

Subtitle B—Quality Assurance

SEC. 111. INTERNAL QUALITY ASSURANCE PROGRAM.

(a) **REQUIREMENT.**—A group health plan, and a health insurance issuer that offers health insurance coverage, shall establish and maintain an ongoing, internal quality assurance and continuous quality improvement program that meets the requirements of subsection (b).

(b) **PROGRAM REQUIREMENTS.**—The requirements of this subsection for a quality improvement program of a plan or issuer are as follows:

(1) **ADMINISTRATION.**—The plan or issuer has a separate identifiable unit with responsibility for administration of the program.

(2) **WRITTEN PLAN.**—The plan or issuer has a written plan for the program that is updated annually and that specifies at least the following:

(A) The activities to be conducted.

(B) The organizational structure.

(C) The duties of the medical director.

(D) Criteria and procedures for the assessment of quality.

(3) **SYSTEMATIC REVIEW.**—The program provides for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes.

(4) **QUALITY CRITERIA.**—The program—

(A) uses criteria that are based on performance and patient outcomes where feasible and appropriate;

(B) includes criteria that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate;

(C) includes methods for informing covered individuals of the benefit of preventive care and what specific benefits with respect to preventive care are covered under the plan or coverage; and

(D) makes available to the public a description of the criteria used under subparagraph (A).

(5) **SYSTEM FOR REPORTING.**—The program has procedures for reporting of possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.

(6) **DATA ANALYSIS.**—The program provides, using data that include the data collected under section 112, for an analysis of the plan's or issuer's performance on quality measures.

(7) **DRUG UTILIZATION REVIEW.**—The program provides for a drug utilization review program in accordance with section 114.

(c) **DEEMING.**—For purposes of subsection (a), the requirements of—

(1) subsection (b) (other than paragraph (5)) are deemed to be met with respect to a health insurance issuer that is a qualified health maintenance organization (as defined in section 1310(c) of the Public Health Service Act); or

(2) subsection (b) are deemed to be met with respect to a health insurance issuer that is accredited by a national accreditation organization that the Secretary certifies as applying, as a condition of certification, standards at least as stringent as those required for a quality improvement program under subsection (b).

(d) **VARIATION PERMITTED.**—The Secretary may provide for variations in the application of the requirements of this section to group health plans and health insurance issuers based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate.

SEC. 112. COLLECTION OF STANDARDIZED DATA.

(a) **IN GENERAL.**—A group health plan and a health insurance issuer that offers health insurance coverage shall collect uniform quality data that include a minimum uniform data set described in subsection (b).

(b) **MINIMUM UNIFORM DATA SET.**—The Secretary shall specify (and may from time to time update) the data required to be included

in the minimum uniform data set under subsection (a) and the standard format for such data. Such data shall include at least—

- (1) aggregate utilization data;
- (2) data on the demographic characteristics of participants, beneficiaries, and enrollees;
- (3) data on disease-specific and age-specific mortality rates and (to the extent feasible) morbidity rates of such individuals;
- (4) data on satisfaction of such individuals, including data on voluntary disenrollment and grievances; and
- (5) data on quality indicators and health outcomes, including, to the extent feasible and appropriate, data on pediatric cases and on a gender-specific basis.

(c) AVAILABILITY.—A summary of the data collected under subsection (a) shall be disclosed under section 121(b)(9). The Secretary shall be provided access to all the data so collected.

(d) VARIATION PERMITTED.—The Secretary may provide for variations in the application of the requirements of this section to group health plans and health insurance issuers based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate.

SEC. 113. PROCESS FOR SELECTION OF PROVIDERS.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care professionals, including minimum professional requirements.

(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license and a history of suspension or revocation.

(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

(d) NONDISCRIMINATION BASED ON LICENSURE.—

(1) IN GENERAL.—Such process shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed—

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

(B) to override any State licensure or scope-of-practice law.

(e) GENERAL NONDISCRIMINATION.—

(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consistent with the Americans with Disabilities Act of 1990).

(2) RULES.—The appropriate Secretary may establish such definitions, rules, and exceptions as may be appropriate to carry out paragraph (1), taking into account comparable definitions, rules, and exceptions in effect under employment-based non-discrimination laws and regulations that re-

late to each of the particular bases for discrimination described in such paragraph.

SEC. 114. DRUG UTILIZATION PROGRAM.

A group health plan, and a health insurance issuer that provides health insurance coverage, that includes benefits for prescription drugs shall establish and maintain, as part of its internal quality assurance and continuous quality improvement program under section 111, a drug utilization program which—

- (1) encourages appropriate use of prescription drugs by participants, beneficiaries, and enrollees and providers, and
- (2) takes appropriate action to reduce the incidence of improper drug use and adverse drug reactions and interactions.

SEC. 115. STANDARDS FOR UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

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

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

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

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians. Such criteria shall include written clinical review criteria described in section 111(b)(4)(B).

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

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions. In this subsection, the term "health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required,

who have received appropriate training in the conduct of such activities under the program.

(B) PEER REVIEW OF SAMPLE OF ADVERSE CLINICAL DETERMINATIONS.—Such a program shall provide that clinical peers (as defined in section 191(c)(2)) shall evaluate the clinical appropriateness of at least a sample of adverse clinical determinations.

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

(i) provides incentives, direct or indirect, for such persons to make inappropriate review decisions, or

(ii) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

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

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

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

(5) LIMITATION ON INFORMATION REQUESTS.—Under such a program, information shall be required to be provided by health care providers only to the extent it is necessary to perform the utilization review activity involved.

(6) REVIEW OF PRELIMINARY UTILIZATION REVIEW DECISION.—Under such program a participant, beneficiary, or enrollee or any provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with a preliminary utilization review decision has the opportunity to discuss the decision with, and have such decision reviewed by, the medical director of the plan or issuer involved (or the director's designee) who has the authority to reverse the decision.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 3 business days after the date of receipt of information that is reasonably necessary to make such determination.

(2) CONTINUED CARE.—In the case of a utilization review activity involving authorization for continued or extended health care services for an individual, or additional services for an individual undergoing a course of continued treatment prescribed by a health care provider, the utilization review program shall make a determination concerning such

authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 1 business day after the date of receipt of information that is reasonably necessary to make such determination. Such notice shall include, with respect to continued or extended health care services, the number of extended services approved, the new total of approved services, the date of onset of services, and the next review date, if any.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination.

(4) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 101, respectively.

(e) NOTICE OF ADVERSE DETERMINATIONS.—

(1) IN GENERAL.—Notice of an adverse determination under a utilization review program shall be provided in printed form and shall include—

(A) the reasons for the determination (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 132; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such determination.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the determination in order to make a decision on such an appeal.

SEC. 116. HEALTH CARE QUALITY ADVISORY BOARD.

(a) ESTABLISHMENT.—The President shall establish an advisory board to provide information to Congress and the administration on issues relating to quality monitoring and improvement in the health care provided under group health plans and health insurance coverage.

(b) NUMBER AND APPOINTMENT.—The advisory board shall be composed of the Secretary of Health and Human Services (or the Secretary's designee), the Secretary of Labor (or the Secretary's designee), and 20 additional members appointed by the President, in consultation with the Majority and Minority Leaders of the Senate and House of Representatives. The members so appointed shall include individuals with expertise in—

(1) consumer needs;

(2) education and training of health professionals;

(3) health care services;

(4) health plan management;

(5) health care accreditation, quality assurance, improvement, measurement, and oversight;

(6) medical practice, including practicing physicians;

(7) prevention and public health; and

(8) public and private group purchasing for small and large employers or groups.

(c) DUTIES.—The advisory board shall—

(1) identify, update, and disseminate measures of health care quality for group health plans and health insurance issuers, including network and non-network plans;

(2) advise the Secretary on the development and maintenance of the minimum data set in section 112(b); and

(3) advise the Secretary on standardized formats for information on group health plans and health insurance coverage.

The measures identified under paragraph (1) may be used on a voluntary basis by such plans and issuers. In carrying out paragraph (1), the advisory board shall consult and cooperate with national health care standard setting bodies which define quality indicators, the Agency for Health Care Policy and Research, the Institute of Medicine, and other public and private entities that have expertise in health care quality.

(d) REPORT.—The advisory board shall provide an annual report to Congress and the President on the quality of the health care in the United States and national and regional trends in health care quality. Such report shall include a description of determinants of health care quality and measurements of practice and quality variability within the United States.

(e) SECRETARIAL CONSULTATION.—In serving on the advisory board, the Secretaries of Health and Human Services and Labor (or their designees) shall consult with the Secretaries responsible for other Federal health insurance and health care programs.

(f) VACANCIES.—Any vacancy on the board shall be filled in such manner as the original appointment. Members of the board shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties. Administrative support, scientific support, and technical assistance for the advisory board shall be provided by the Secretary of Health and Human Services.

(g) CONTINUATION.—Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the advisory board.

Subtitle C—Patient Information

SEC. 121. PATIENT INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

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

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

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

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

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

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

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

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

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

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

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

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

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

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

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

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

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

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

(B) Out-of-network coverage (if any) provided by the plan or coverage.

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

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

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

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 103(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals and including the provision of information in a language other than English if 5 percent of the number of participants, beneficiaries, and enrollees communicate in that language instead of English.

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

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

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

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

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer, and the availability of assistance through an ombudsman to individuals in relation to group health plans and health insurance coverage.

(9) QUALITY ASSURANCE.—A summary description of the data on quality collected under section 112(a), including a summary description of the data on satisfaction of participants, beneficiaries, and enrollees (including data on individual voluntary disenrollment and grievances and appeals) described in section 112(b)(4).

(10) SUMMARY OF PROVIDER FINANCIAL INCENTIVES.—A summary description of the information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

(11) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 115, including under any drug formulary program under section 107.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians, including information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

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

(5) CONFIDENTIALITY POLICIES AND PROCEDURES.—A description of the policies and procedures established to carry out section 122.

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

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

(d) FORM OF DISCLOSURE.—

(1) UNIFORMITY.—Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable

State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area.

(2) INFORMATION INTO HANDBOOK.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from making the information under subsections (b) and (c) available to participants, beneficiaries, and enrollees through an enrollee handbook or similar publication.

(3) UPDATING PARTICIPATING PROVIDER INFORMATION.—The information on participating health care providers described in subsection (b)(3)(C) shall be updated within such reasonable period as determined appropriate by the Secretary. Nothing in this section shall prevent an issuer from changing or updating other information made available under this section.

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

SEC. 122. PROTECTION OF PATIENT CONFIDENTIALITY.

Insofar as a group health plan, or a health insurance issuer that offers health insurance coverage, maintains medical records or other health information regarding participants, beneficiaries, and enrollees, the plan or issuer shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely, and

(3) to assure timely access of such individuals to such records and information.

SEC. 123. HEALTH INSURANCE OMBUDSMEN.

(a) IN GENERAL.—Each State that obtains a grant under subsection (c) shall provide for creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers. Such Ombudsman shall be responsible for at least the following:

(1) To assist consumers in the State in choosing among health insurance coverage or among coverage options offered within group health plans.

(2) To provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers and group health plans in regard to such coverage or plans and with respect to grievances and appeals regarding determinations under such coverage or plans.

(b) FEDERAL ROLE.—In the case of any State that does not provide for such an Ombudsman under subsection (a), the Secretary shall provide for the creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers and that is responsible for carrying out with respect to that State the functions otherwise provided under subsection (a) by a Health Insurance Ombudsman.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services such amounts as may be necessary to provide for grants to States for contracts for Health Insurance Ombudsmen under subsection (a) or contracts for such Ombudsmen under subsection (b).

(d) CONSTRUCTION.—Nothing in this section shall be construed to prevent the use of other forms of enrollee assistance.

Subtitle D—Grievance and Appeals Procedures

SEC. 131. ESTABLISHMENT OF GRIEVANCE PROCESSES.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent, regarding any aspect of the plan's or issuer's services.

(2) SCOPE.—The system shall include grievances regarding access to and availability of services, quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this title.

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

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

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

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

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

(5) Notification to the continuous quality improvement program under section 111(a) of all grievances and appeals relating to quality of care.

SEC. 132. INTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT OF APPEAL.—

(1) IN GENERAL.—A participant or beneficiary in a group health plan, and an enrollee in health insurance coverage offered by a health insurance issuer, and any provider or other person acting on behalf of such an individual with the individual's consent, may appeal any appealable decision (as defined in paragraph (2)) under the procedures described in this section and (to the extent applicable) section 133. Such individuals and providers shall be provided with a written explanation of the appeal process and the determination upon the conclusion of the appeals process and as provided in section 121(b)(8).

(2) APPEALABLE DECISION DEFINED.—In this section, the term "appealable decision" means any of the following:

(A) Denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(B) Failure to provide coverage of emergency services or reimbursement of maintenance care or post-stabilization care under section 101.

(C) Failure to provide a choice of provider under section 103.

(D) Failure to provide qualified health care providers under section 103.

(E) Failure to provide access to specialty and other care under section 104.

(F) Failure to provide continuation of care under section 105.

(G) Failure to provide coverage of routine patient costs in connection with an approval clinical trial under section 106.

(H) Failure to provide access to needed drugs under section 107(a)(3) or 107(b).

(I) Discrimination in delivery of services in violation of section 109.

(J) An adverse determination under a utilization review program under section 115.

(K) The imposition of a limitation that is prohibited under section 151.

(b) INTERNAL APPEAL PROCESS.—

(1) **IN GENERAL.**—Each group health plan and health insurance issuer shall establish and maintain an internal appeal process under which any participant, beneficiary, enrollee, or provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with any appealable decision has the opportunity to appeal the decision through an internal appeal process. The appeal may be communicated orally.

(2) CONDUCT OF REVIEW.—

(A) **IN GENERAL.**—The process shall include a review of the decision by a physician or other health care professional (or professionals) who has been selected by the plan or issuer and who has not been involved in the appealable decision at issue in the appeal.

(B) **AVAILABILITY AND PARTICIPATION OF CLINICAL PEERS.**—The individuals conducting such review shall include one or more clinical peers (as defined in section 191(c)(2)) who have not been involved in the appealable decision at issue in the appeal.

(3) DEADLINE.—

(A) **IN GENERAL.**—Subject to subsection (c), the plan or issuer shall conclude each appeal as soon as possible after the time of the receipt of the appeal in accordance with medical exigencies of the case involved, but in no event later than—

(i) 72 hours after the time of receipt of an expedited appeal, and

(ii) except as provided in subparagraph (B), 30 business days after such time (or, if the participant, beneficiary, or enrollee supplies additional information that was not available to the plan or issuer at the time of the receipt of the appeal, after the date of supplying such additional information) in the case of all other appeals.

(B) **EXTENSION.**—In the case of an appeal that does not relate to a decision regarding an expedited appeal and that does not involve medical exigencies, if a group health plan or health insurance issuer is unable to conclude the appeal within the time period provided under subparagraph (A)(ii) due to circumstances beyond the control of the plan or issuer, the deadline shall be extended for up to an additional 10 business days if the plan or issuer provides, on or before 10 days before the deadline otherwise applicable, written notice to the participant, beneficiary, or enrollee and the provider involved of the extension and the reasons for the extension.

(4) **NOTICE.**—If a plan or issuer denies an appeal, the plan or issuer shall provide the participant, beneficiary, or enrollee and provider involved with notice in printed form of the denial and the reasons therefore, together with a notice in printed form of rights to any further appeal.

(c) EXPEDITED REVIEW PROCESS.—

(1) **IN GENERAL.**—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of appeals under subsection (b) in situations in which the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function.

(2) PROCESS.—Under such procedures—

(A) the request for expedited appeal may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the appeal;

(B) all necessary information, including the plan's or issuer's decision, shall be trans-

mitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the appeal if the request for an expedited appeal is submitted under subparagraph (A) by a physician and the request indicates that the situation described in paragraph (1) exists.

(d) **DIRECT USE OF FURTHER APPEALS.**—In the event that the plan or issuer fails to comply with any of the deadlines for completion of appeals under this section or in the event that the plan or issuer for any reason expressly waives its rights to an internal review of an appeal under subsection (b), the participant, beneficiary, or enrollee involved and the provider involved shall be relieved of any obligation to complete the appeal involved and may, at such an individual's or provider's option, proceed directly to seek further appeal through any applicable external appeals process.

SEC. 133. EXTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) **IN GENERAL.**—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2). The appropriate Secretary shall establish standards to carry out such requirements.

(2) **EXTERNALLY APPEALABLE DECISION DEFINED.**—For purposes of this section, the term "externally appealable decision" means an appealable decision (as defined in section 132(a)(2)) if—

(A) the amount involved exceeds a significant threshold; or

(B) the patient's life or health is jeopardized as a consequence of the decision. Such term does not include a denial of coverage for services that are specifically listed in plan or coverage documents as excluded from coverage.

(3) **EXHAUSTION OF INTERNAL APPEALS PROCESS.**—A plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon completion of the internal review process provided under section 132, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(b) **GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—**

(1) **CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—**

(A) **CONTRACT REQUIREMENT.**—Subject to subparagraph (B), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) **RESTRICTIONS ON QUALIFIED EXTERNAL APPEAL ENTITY.—**

(i) **BY STATE FOR HEALTH INSURANCE ISSUERS.**—With respect to health insurance issuers in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in such a manner as to assure an unbiased determination.

(ii) **BY FEDERAL GOVERNMENT FOR GROUP HEALTH PLANS.**—With respect to group health plans, the appropriate Secretary may exercise the same authority as a State may exercise with respect to health insurance issuers under clause (i). Such authority may include requiring the use of the qualified external appeal entity designated or selected under such clause.

(iii) **LIMITATION ON PLAN OR ISSUER SELECTION.**—If an applicable authority permits

more than one entity to qualify as a qualified external appeal entity with respect to a group health plan or health insurance issuer and the plan or issuer may select among such qualified entities, the applicable authority—

(I) shall assure that the selection process will not create any incentives for external appeal entities to make a decision in a biased manner, and

(II) shall implement procedures for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) **OTHER TERMS AND CONDITIONS.**—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that the direct costs of the process (not including costs of representation of a participant, beneficiary, or enrollee) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee.

(2) **ELEMENTS OF PROCESS.**—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) **FAIR PROCESS; DE NOVO DETERMINATION.**—The process shall provide for a fair, de novo determination.

(B) **DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.**—A qualified external appeal entity shall determine whether a decision is an externally appealable decision and related decisions, including—

(i) whether such a decision involves an expedited appeal;

(ii) the appropriate deadlines for internal review process required due to medical exigencies in a case; and

(iii) whether such a process has been completed.

(C) **OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.**—Each party to an externally appealable decision—

(i) may submit and review evidence related to the issues in dispute,

(ii) may use the assistance or representation of one or more individuals (any of whom may be an attorney), and

(iii) may make an oral presentation.

(D) **PROVISION OF INFORMATION.**—The plan or issuer involved shall provide timely access to all its records relating to the matter of the externally appealable decision and to all provisions of the plan or health insurance coverage (including any coverage manual) relating to the matter.

(E) **TIMELY DECISIONS.**—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be binding on the plan or issuer;

(iii) be made in accordance with the medical exigencies of the case involved, but in no event later than 60 days (or 72 hours in the case of an expedited appeal) from the date of completion of the filing of notice of external appeal of the decision;

(iv) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(v) inform the participant, beneficiary, or enrollee of the individual's rights to seek further review by the courts (or other process) of the external appeal determination.

(c) **QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—**

(1) IN GENERAL.—For purposes of this section, the term “qualified external appeal entity” means, in relation to a plan or issuer, an entity (which may be a governmental entity) that is certified under paragraph (2) as meeting the following requirements:

(A) There is no real or apparent conflict of interest that would impede the entity conducting external appeal activities independent of the plan or issuer.

(B) The entity conducts external appeal activities through clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(3)(E).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1) by the Secretary of Labor (or under a process recognized or approved by the Secretary of Labor); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements by the applicable State authority (or, if the States has not established an adequate certification and recertification process, by the Secretary of Health and Human Services, or under a process recognized or approved by such Secretary).

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

(i) the information required to be submitted as a condition of recertification on the entity’s performance of external appeal activities, which information shall include the number of cases reviewed, a summary of the disposition of those cases, the length of time in making determinations on those cases, and such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted; and

(ii) the periodicity which recertification will be required.

(d) CONTINUING LEGAL RIGHTS OF ENROLLEES.—Nothing in this title shall be construed as removing any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law, including the right to file judicial actions to enforce rights.

Subtitle E—Protecting the Doctor-Patient Relationship

SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) PROHIBITION.—

(1) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider’s patient.

(2) NULLIFICATION.—Any contract provision or agreement described in paragraph (1) shall be null and void.

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

(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan or health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

(2) to permit a health care provider to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan health insurance issuer to reimburse providers for benefits not covered under the plan or coverage.

(c) MEDICAL COMMUNICATION DEFINED.—In this section:

(1) IN GENERAL.—The term “medical communication” means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

(A) the patient’s health status, medical care, or treatment options;

(B) any utilization review requirements that may affect treatment options for the patient; or

(C) any financial incentives that may affect the treatment of the patient.

(2) MISREPRESENTATION.—The term “medical communication” does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) if the communication involves a knowing or willful misrepresentation by such provider.

SEC. 142. PROHIBITION AGAINST TRANSFER OF INDEMNIFICATION OR IMPROPER INCENTIVE ARRANGEMENTS.

(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in subparagraph (A) of such section are met with respect to such a plan.

(2) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

SEC. 143. ADDITIONAL RULES REGARDING PARTICIPATION OF HEALTH CARE PROFESSIONALS.

(a) PROCEDURES.—Insofar as a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits through participating health care professionals, the plan or issuer shall establish reasonable procedures relating to the participation (under an agreement between a professional and the plan or issuer) of such professionals under the plan or coverage. Such procedures shall include—

(1) providing notice of the rules regarding participation;

(2) providing written notice of participation decisions that are adverse to professionals; and

(3) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

(b) CONSULTATION IN MEDICAL POLICIES.—A group health plan, and health insurance issuer that offers health insurance coverage, shall consult with participating physicians (if any) regarding the plan’s or issuer’s medical policy, quality, and medical management procedures.

SEC. 144. PROTECTION FOR PATIENT ADVOCACY.

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

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

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

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

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

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

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

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

the same licensure or certification and the same experience;

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

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

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

(3) EXCEPTION AND SPECIAL RULE.—

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

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

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

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

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

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

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

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

(6) CONSTRUCTIONS.—

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

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

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enroll-

ees, and protected health care professionals under other applicable Federal or State laws.

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

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

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle F—Promoting Good Medical Practice

SEC. 151. PROMOTING GOOD MEDICAL PRACTICE.

(a) PROHIBITING ARBITRARY LIMITATIONS OR CONDITIONS FOR THE PROVISION OF SERVICES.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed as prohibiting a plan or issuer from limiting the delivery of services to one or more health care providers within a network of such providers.

(3) MANNER OR SETTING DEFINED.—In paragraph (1), the term “manner or setting” means the location of treatment, such as whether treatment is provided on an inpatient or outpatient basis, and the duration of treatment, such as the number of days in a hospital. Such term does not include the coverage of a particular service or treatment.

(b) NO CHANGE IN COVERAGE.—Subsection (a) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the plan or coverage or from conducting utilization review activities consistent with this subsection.

(c) MEDICAL NECESSITY OR APPROPRIATENESS DEFINED.—In subsection (a), the term “medically necessary or appropriate” means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice.

SEC. 152. STANDARDS RELATING TO BENEFITS FOR CERTAIN BREAST CANCER TREATMENT.

(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING MASTECTOMY OR LYMPH NODE DISSECTION.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with a mastectomy for the treatment of breast cancer to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health

plan or health insurance issuer in any case in which the decision to discharge the woman involved prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by the attending provider in consultation with the woman or in a case involving a partial mastectomy without lymph node dissection.

(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to women to encourage such women to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a woman who is a participant or beneficiary—

(A) to undergo a mastectomy or lymph node dissection in a hospital; or

(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1) of the Public Health Service Act) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital

length of stay following a mastectomy performed for treatment of breast cancer and at least a 24-hour hospital length of stay following a lymph node dissection for treatment of breast cancer.

(B) Such State law requires, in connection with such coverage for surgical treatment of breast cancer, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the woman involved.

(2) CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act and section 731(a)(1) of the Employee Retirement Income Security Act of 1974 shall not be construed as superseding a State law described in paragraph (1).

SEC. 153. STANDARDS RELATING TO BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY.

(a) REQUIREMENTS FOR RECONSTRUCTIVE BREAST SURGERY.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for breast surgery in connection with a mastectomy shall provide coverage for reconstructive breast surgery resulting from the mastectomy. Such coverage shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased when reconstruction on the diseased breast is performed and coverage of prostheses and complications of mastectomy including lymphedema.

(2) RECONSTRUCTIVE BREAST SURGERY DEFINED.—In this section, the term “reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between two breasts, and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(3) MASTECTOMY DEFINED.—In this section, the term “mastectomy” means the surgical removal of all or part of a breast.

(b) PROHIBITIONS.—

(1) DENIAL OF COVERAGE BASED ON COSMETIC SURGERY.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not deny coverage described in subsection (a)(1) on the basis that the coverage is for cosmetic surgery.

(2) APPLICATION OF SIMILAR PROHIBITIONS.—Paragraphs (2) through (5) of section 152 shall apply under this section in the same manner as they apply with respect to section 152.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a woman who is a participant or beneficiary to undergo reconstructive breast surgery.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for mastectomies.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for reconstructive breast surgery under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion may not be greater than such coinsurance or cost-sharing that is otherwise applicable with respect to benefits for mastectomies.

(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for

care provided in accordance with this section.

(f) EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1) of the Public Health Service Act) for a State that regulates such coverage and that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.

(2) CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act and section 731(a)(1) of the Employee Retirement Income Security Act of 1974 shall not be construed as superseding a State law described in paragraph (1).

Subtitle G—Definitions

SEC. 191. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—The provisions of section 2971 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term “Secretary” means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the Secretary of the Treasury and the term “appropriate Secretary” means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act, the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974, and the Secretary of the Treasury in relation to carrying out this title under chapter 100 and section 4980D of the Internal Revenue Code of 1986.

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

(1) APPLICABLE AUTHORITY.—The term “applicable authority” means—

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

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

(2) CLINICAL PEER.—The term “clinical peer” means, with respect to a review or appeal, a physician (allopathic or osteopathic) or other health care professional who holds a non-restricted license in a State and who is appropriately credentialed in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment rendered by a physician.

(3) HEALTH CARE PROVIDER.—The term “health care provider” includes a physician or other health care professional, as well as an institutional provider of health care services.

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

(5) PARTICIPATING.—The term “participating” mean, with respect to a health care pro-

vider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

SEC. 192. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

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

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

(b) RULES OF CONSTRUCTION.—Except as provided in sections 152 and 153, nothing in this title shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

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

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

(2) STATE.—The term “State” includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

SEC. 193. REGULATIONS.

The Secretaries of Health and Human Services, Labor, and the Treasury shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

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

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

“SEC. 2706. PATIENT PROTECTION STANDARDS.

“(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Patients’ Bill of Rights Act of 1998, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

“(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to

the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.”.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg-21(b)(2)(A)) is amended by inserting “(other than section 2706)” after “requirements of such subparts”.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

“SEC. 2752. PATIENT PROTECTION STANDARDS.

“(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Patients’ Bill of Rights Act of 1998 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

“(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.”.

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.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

“SEC. 713. PATIENT PROTECTION STANDARDS.

“(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Patients’ Bill of Rights Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

“(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

“(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Patients’ Bill of Rights Act of 1998 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

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

“(B) Section 102(a)(1) (relating to offering option to purchase point-of-service coverage), but only insofar as the plan is meeting such requirement through an agreement with the issuer to offer the option to purchase point-of-service coverage under such section.

“(C) Section 103 (relating to choice of providers).

“(D) Section 104 (relating to access to specialty care).

“(E) Section 105(a)(1) (relating to continuity in case of termination of provider contract) and section 105(a)(2) (relating to con-

tinuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

“(F) Section 106 (relating to coverage for individuals participating in approved clinical trials.)

“(G) Section 107 (relating to access to needed prescription drugs).

“(H) Section 108 (relating to adequacy of provider network).

“(I) Subtitle B (relating to quality assurance).

“(J) Section 143 (relating to additional rules regarding participation of health care professionals).

“(K) Section 152 (relating to standards relating to benefits for certain breast cancer treatment).

“(L) Section 153 (relating to standards relating to benefits for reconstructive breast surgery).

“(2) INFORMATION.—With respect to information required to be provided or made available under section 121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer’s failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

“(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under sections 131 and 132, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such system and process (and is not liable for the issuer’s failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

“(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 133, the plan shall be treated as meeting the requirement of such section and is not liable for the entity’s failure to meet any requirements under such section.

“(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

“(A) Section 109 (relating to non-discrimination in delivery of services).

“(B) Section 141 (relating to prohibition of interference with certain medical communications).

“(C) Section 142 (relating to prohibition against transfer of indemnification or improper incentive arrangements).

“(D) Section 144 (relating to prohibition on retaliation).

“(E) Section 151 (relating to promoting good medical practice).

“(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

“(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 144(b)(1) of the Patients’ Bill of Rights Act of 1998, for purposes of this subtitle the term

‘group health plan’ is deemed to include a reference to an institutional health care provider.

“(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

“(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 144(b)(1) of the Patients’ Bill of Rights Act of 1998 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

“(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

“(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.”.

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

“(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle D (and section 115) of title I of the Patients’ Bill of Rights Act of 1998 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.”.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711 and 713”.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

“Sec. 713. Patient protection standards.”.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting “(other than section 144(b))” after “part 7”.

SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICY-HOLDERS.

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

“(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

“(1) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action brought by a plan participant or beneficiary (or the estate of a plan participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

“(A) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan (as defined in section 733), or

“(B) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

For purposes of this subsection, the term ‘personal injury’ means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

“(2) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

“(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

“(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

“(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

“(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) if—

“(i) such action is based on the employer's or other plan sponsor's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

“(ii) the exercise by such employer or other plan sponsor (or employee) of such authority resulted in personal injury or wrongful death.

“(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is not covered under the group health plan involved.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

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

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 1531(a) of the Taxpayer Relief Act of 1997) is amended—

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

“Sec. 9813. Standard relating to patient freedom of choice.”; and

(2) by inserting after section 9812 the following:

“SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

“A group health plan shall comply with the requirements of title I of the Patients' Bill of Rights Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.”.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 1999 (in this section referred to as the “general effective date”).

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

Section 104(l) of Health Insurance Portability and Accountability Act of 1996 is amended by striking “this subtitle (and the amendments made by this subtitle and section 401)” and inserting “the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, chapter 100 of the Internal Revenue Code of 1986, and title I of the Patients' Bill of Rights Act of 1998”.

TITLE VI—REVENUE PROVISIONS

SEC. 601. ESTATE TAX TECHNICAL CORRECTION.

(a) IN GENERAL.—Paragraph (2) of section 2001(c) of the Internal Revenue Code of 1986 is amended by striking “\$10,000,000” and all that follows and inserting “\$10,000,000. The amount of the increase under the preceding sentence shall not exceed the sum of the applicable credit amount under section 2010(c) (determined without regard to section 2057(a)(3)) and \$359,200.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 501 of the Taxpayer Relief Act of 1997.

SEC. 602. TREATMENT OF CERTAIN DEDUCTIBLE LIQUIDATING DISTRIBUTIONS OF REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.

(a) IN GENERAL.—Section 332 of the Internal Revenue Code of 1986 (relating to complete liquidations of subsidiaries) is amended by adding at the end the following new subsection:

“(c) DEDUCTIBLE LIQUIDATING DISTRIBUTIONS OF REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.—If a corporation receives a distribution from a regulated investment company or a real estate investment trust which is considered under subsection (b) as being in complete liquidation of such company or trust, then, notwithstanding any other provision of this chapter, such corporation shall recognize and treat as a dividend from such company or trust an amount equal to the deduction for dividends paid allowable to such company or trust by reason of such distribution.”.

(b) CONFORMING AMENDMENTS.—

(1) The material preceding paragraph (1) of section 332(b) of such Code is amended by striking “subsection (a)” and inserting “this section”.

(2) Paragraph (1) of section 334(b) of such Code is amended by striking “section 332(a)” and inserting “section 332”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after May 21, 1998.

The SPEAKER pro tempore. Pursuant to House Resolution 509, the gentleman from Michigan (Mr. DINGELL)

and the gentleman from Illinois (Mr. HASTERT) each will control 30 minutes.

The Chair recognizes the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE), my distinguished friend, for purposes of offering the amendment.

Mr. GANSKE. Mr. Speaker, I rise in support of the Ganske-Dingell substitute. This substitute is supported by Consumers Union, other consumer groups, about 170 health groups, both consumer groups and provider groups. It is supported by the AARP, it is supported by the AMA, the Nurses Association, and by the AFL-CIO. It has broad, widespread support, for a good reason.

Let me specifically address my friend LINDSEY GRAHAM's comments about the underlying Republican bill and how it relates to the substitute on liability. My friend LINDSEY GRAHAM is trying to improve the GOP bill.

Consider the family of Joyce Chiang. Her complaints of severe abdominal pain and requests for a referral to a specialist went unheeded. The delay prevented the timely discovery of a colon cancer that might have been cured. Instead, by the time she got the additional tests she requested, the cancer had perforated her bowel and no amount of surgery could save her.

Under the Hastert bill, Joyce Chiang's family could only collect \$500 for every day the care was denied. But I would say that is hardly an effective remedy or deterrent, when it can cost health plans more to provide the needed care than it would potentially cost them in a subsequent legal action.

Mr. Speaker, I am not interested in granting tobacco companies legal protections for their conduct; and I cannot see how it serves our constituents to allow health plans who are making life-and-death decisions to hide from their consequences.

Republicans believe in personal responsibility, and this immunity that is preserved in the Hastert bill flies in the face of that. Health plans should be treated like any other industry and held accountable for their negligent actions.

Furthermore, the GOP bill does not get at a fundamental underlying problem, and that is that the HMOs can define what is medically necessary. Before our Committee on Commerce we had a medical reviewer describe how she had made decisions that resulted in the loss of life because she could manipulate the way the HMO defined “medically necessary.” Under the Ganske-Dingell bill, we address that problem. Their bill does not.

I strongly urge my Republican colleagues to vote for the best bill, the one that addresses the smart bomb of HMOs, the issue of what is defined as “medically necessary.”

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding.

I am a practicing physician. And I do not plan on staying in this body. I plan on returning in a few short years to my practice. And I think it is a wonderful thing that we are having this debate today. We both want to do what we can to restore the doctor-patient relationship. We both want to do what we can to return quality as number one in health care in the United States. They have their plan. We have ours.

Now, I believe that there is an important feature in our bill that makes our bill the better bill over their bill. But I want to address a few points made by my colleague the gentleman from Iowa (Mr. GANSKE).

I served on the task force that produced this bill, and one of the most important things that I was going after was timely access to specialists. And contrary to the claims that were made by him and the claims by others, we have important language in our bill that will require people in managed care entities to have timely access to specialists.

Here is the difference between their bill and our bill, and I will tell my colleagues about it. I was on a radio talk show last week where a lady called in and she was saying some bad things about her HMO and she said, "The other HMO I was in was just as bad. I had switched." I said, "What do you mean, you switched from one HMO to another HMO? Are you in the FEHBP plan?" And she said, "Yes." And I said, "Well, you know, I am in that, too; and there are some better plans that you could select. Why didn't you select one of those better coverage plans?" And do you know what she said to me? "Well, we cannot afford it. That is why I am in an HMO."

Now, we are to be led to believe by our colleagues on the other side of the aisle that their bill which is going to place all these government mandates is not going to drive up costs for that lady?

Let me tell my colleagues something. Every month in my practice a clerk from my billing office brought a stack of charts of working people who were not able to pay their bills and I did what thousands of other physicians all across America do; I wrote off those bills, thousands of dollars every year. Why? Because those people had no health insurance.

Now we are led to believe by these folks that they here in Washington are going to make all these HMOs do all these wonderful things that are mandated in their bill and it is not going to drive up costs, it is not going to increase the number of uninsured?

Let me tell my colleagues something. We have a good bill here that is going to work very hard to restore quality and it is not going to drive up costs. Indeed, we believe the provisions in this bill, which allow small employers to pool, which has malpractice reform, is actually going to drive down costs. It

is going to allow more people to get insurance.

We have, in my opinion, the better bill. And I can say that as somebody who is going to go back in a few short years to be working in the system.

PERMISSION TO FILE CONFERENCE REPORT ON H.R. 4059, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 1999

Mr. LIVINGSTON. Mr. Speaker, I ask unanimous consent that the managers on the part of the House may have until midnight tonight, Friday, July 24, 1998, to file a conference report on the bill (H.R. 4059) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

PERMISSION FOR COMMITTEE ON APPROPRIATIONS TO FILE PRIVILEGED REPORT ON DEPARTMENT OF TRANSPORTATION AND RELATED AGENCIES APPROPRIATION BILL, 1999

Mr. LIVINGSTON. Mr. Speaker, I ask unanimous consent that the Committee on Appropriations may have until midnight tonight, July 24, 1998, to file a privileged report on a bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

The SPEAKER pro tempore. Pursuant to the provisions of clause 8 of rule XXI, the Chair reserves all points of order on the bill.

□ 1215

PATIENT PROTECTION ACT OF 1998

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. LATOURETTE).

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

Mr. LATOURETTE. Mr. Speaker, I want to thank the dean of the House the gentleman from Michigan (Mr. DINGELL) and my classmate the gentleman from Iowa (Mr. GANSKE) for the opportunity to address my support for the Patient Bill of Rights. I also want to thank the gentleman from Illinois (Mr. HASTERT) for doing what he thinks is the right thing.

Obviously there is a slight concern when you endorse a proposal that is labeled the Democratic bill when you are a Republican and vice versa. While I am saddened that this issue has a par-

tisan spin to it, today I am driven to support the initiative that I believe gives the greatest protection and possibility of care for the people that I represent. That bill is Ganske-Dingell.

I want to direct my remarks to the liability provisions, however, relating to employer-provided health care plans. Being a lawyer, I like that profession as well as any other, but I am sensitive to the concerns of small business owners, many of whom administer their own plans, about the liability problem. Some of the calls our office has received have been driven from K Street, but many others have come from business owners who are operating on small margins and who want to do the right thing by their employees.

Last night, therefore, I read and I reread page 66 of the Ganske bill concerning liability, and it only reinforced my belief that employers have been needlessly frightened, similar, I am sad to say, to the shameful way seniors were frightened during the Medicare debates.

The only time that an employer is exposed to liability is when the employer makes discretionary medical decisions. Not a doctor, not a hospital, not a nurse, not an HMO. I cannot even think of one situation where an employer would want to make a medical decision, good, bad or otherwise.

Nevertheless, I would ask the sponsors of the bill to tighten the language of the employers' exception in conference. The one thing that I do know about my profession is that they have a unique ability to take words that seem to say one thing and then get a judge somewhere, usually an appointed one, to interpret them in another.

I urge passage of the substitute and would ask both parties to work diligently in conference to create a product that represents the best of both bills. I would ask that we not be about the business of creating campaign commercials here on the floor today but we be about the business of helping Americans of all ages receive the care that they need.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Arkansas (Mr. DICKEY).

Mr. DICKEY. Mr. Speaker, I come here as a former small business owner and as a lawyer. When I first looked at this situation, I looked at it from the doctor's standpoint and I saw a tremendous need, dire circumstances that doctors are facing, even to the extent that we were going to lose doctors presently existing and applicants were not going to apply. And I rushed in with my philosophical approach to this and said, "We've got to help the doctors at all costs." What I found out was that "at all costs" meant the cure was going to be worse than the disease, that the small business owners were going to be killed by being put into courtrooms without any type of protection and in greater numbers.

So what I wanted to do was to try to look at the patients and say we need to