

Calendar No. 164

106TH CONGRESS
1ST Session

S. 1256

A BILL

Entitled the "Patients' Bill of Rights".

JUNE 22, 1999

Read the second time and placed on the calendar

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106TH CONGRESS
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Entitled the "Patients' Bill of Rights".

IN THE SENATE OF THE UNITED STATES

JUNE 21, 1999

Mr. DASCHLE introduced the following bill; which was read the first time

JUNE 22, 1999

Read the second time and placed on the calendar

A BILL

Entitled the "Patients' Bill of Rights".

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

3 **SEC. ___01. SHORT TITLE.**

4 This title may be cited as the "Patients' Bill of
5 Rights Act of 1999".

1 **Subtitle A—Health Insurance Bill**
2 **of Rights**

3 CHAPTER 1—ACCESS TO CARE

4 **SEC. ___ 101. ACCESS TO EMERGENCY CARE.**

5 (a) COVERAGE OF EMERGENCY SERVICES.—

6 (1) IN GENERAL.—If a group health plan, or
7 health insurance coverage offered by a health insur-
8 ance issuer, provides any benefits with respect to
9 emergency services (as defined in paragraph (2)(B)),
10 the plan or issuer shall cover emergency services fur-
11 nished under the plan or coverage—

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

14 (B) whether or not the health care pro-
15 vider furnishing such services is a participating
16 provider with respect to such services;

17 (C) in a manner so that, if such services
18 are provided to a participant, beneficiary, or en-
19 rollee by a nonparticipating health care provider
20 without prior authorization by the plan or
21 issuer, the participant, beneficiary, or enrollee
22 is not liable for amounts that exceed the
23 amounts of liability that would be incurred if
24 the services were provided by a participating

1 health care provider with prior authorization by
2 the plan or issuer; and

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

12 (2) DEFINITIONS.—In this section:

13 (A) EMERGENCY MEDICAL CONDITION
14 BASED ON PRUDENT LAYPERSON STANDARD.—
15 The term “emergency medical condition” means
16 a medical condition manifesting itself by acute
17 symptoms of sufficient severity (including se-
18 vere pain) such that a prudent layperson, who
19 possesses an average knowledge of health and
20 medicine, could reasonably expect the absence
21 of immediate medical attention to result in a
22 condition described in clause (i), (ii), or (iii) of
23 section 1867(e)(1)(A) of the Social Security
24 Act.

1 (B) EMERGENCY SERVICES.—The term
2 “emergency services” means—

3 (i) a medical screening examination
4 (as required under section 1867 of the So-
5 cial Security Act) that is within the capa-
6 bility of the emergency department of a
7 hospital, including ancillary services rou-
8 tinely available to the emergency depart-
9 ment to evaluate an emergency medical
10 condition (as defined in subparagraph
11 (A)), and

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

17 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND
18 POST-STABILIZATION CARE.—In the case of services
19 (other than emergency services) for which benefits are
20 available under a group health plan, or under health insur-
21 ance coverage offered by a health insurance issuer, the
22 plan or issuer shall provide for reimbursement with re-
23 spect to such services provided to a participant, bene-
24 ficiary, or enrollee other than through a participating
25 health care provider in a manner consistent with sub-

1 section (a)(1)(C) (and shall otherwise comply with the
2 guidelines established under section 1852(d)(2) of the So-
3 cial Security Act (relating to promoting efficient and time-
4 ly coordination of appropriate maintenance and post-sta-
5 bilization care of an enrollee after an enrollee has been
6 determined to be stable), or, in the absence of guidelines
7 under such section, such guidelines as the Secretary shall
8 establish to carry out this subsection), if the services are
9 maintenance care or post-stabilization care covered under
10 such guidelines.

11 **SEC. ___102. OFFERING OF CHOICE OF COVERAGE OP-**
12 **TIONS UNDER GROUP HEALTH PLANS.**

13 (a) REQUIREMENT.—

14 (1) OFFERING OF POINT-OF-SERVICE COV-
15 ERAGE OPTION.—Except as provided in paragraph
16 (2), if a group health plan (or health insurance cov-
17 erage offered by a health insurance issuer in connec-
18 tion with a group health plan) provides benefits only
19 through participating health care providers, the plan
20 or issuer shall offer the participant the option to
21 purchase point-of-service coverage (as defined in
22 subsection (b)) for all such benefits for which cov-
23 erage is otherwise so limited. Such option shall be
24 made available to the participant at the time of en-
25 rollment under the plan or coverage and at such

1 other times as the plan or issuer offers the partici-
2 pant a choice of coverage options.

3 (2) EXCEPTION.—Paragraph (1) shall not
4 apply with respect to a participant in a group health
5 plan if the plan offers the participant—

6 (A) a choice of health insurance coverage;

7 and

8 (B) one or more coverage options that do
9 not provide benefits only through participating
10 health care providers.

11 (b) POINT-OF-SERVICE COVERAGE DEFINED.—In
12 this section, the term “point-of-service coverage” means,
13 with respect to benefits covered under a group health plan
14 or health insurance issuer, coverage of such benefits when
15 provided by a nonparticipating health care provider. Such
16 coverage need not include coverage of providers that the
17 plan or issuer excludes because of fraud, quality, or similar
18 reasons.

19 (c) CONSTRUCTION.—Nothing in this section shall be
20 construed—

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

23 (2) as requiring an employer to pay any costs
24 as a result of this section or to make equal contribu-

1 tions with respect to different health coverage op-
 2 tions; or

3 (3) as preventing a group health plan or health
 4 insurance issuer from imposing higher premiums or
 5 cost-sharing on a participant for the exercise of a
 6 point-of-service coverage option.

7 (d) NO REQUIREMENT FOR GUARANTEED AVAIL-
 8 ABILITY.—If a health insurance issuer offers health insur-
 9 ance coverage that includes point-of-service coverage with
 10 respect to an employer solely in order to meet the require-
 11 ment of subsection (a), nothing in section 2711(a)(1)(A)
 12 of the Public Health Service Act shall be construed as re-
 13 quiring the offering of such coverage with respect to an-
 14 other employer.

15 **SEC. ___ 103. CHOICE OF PROVIDERS.**

16 (a) PRIMARY CARE.—A group health plan, and a
 17 health insurance issuer that offers health insurance cov-
 18 erage, shall permit each participant, beneficiary, and en-
 19 rollee to receive primary care from any participating pri-
 20 mary care provider who is available to accept such indi-
 21 vidual.

22 (b) SPECIALISTS.—

23 (1) IN GENERAL.—Subject to paragraph (2), a
 24 group health plan and a health insurance issuer that
 25 offers health insurance coverage shall permit each

1 participant, beneficiary, or enrollee to receive medi-
 2 cally necessary or appropriate specialty care, pursu-
 3 ant to appropriate referral procedures, from any
 4 qualified participating health care provider who is
 5 available to accept such individual for such care.

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

11 **SEC. ___ 104. ACCESS TO SPECIALTY CARE.**

12 (a) OBSTETRICAL AND GYNECOLOGICAL CARE.—

13 (1) IN GENERAL.—If a group health plan, or a
 14 health insurance issuer in connection with the provi-
 15 sion of health insurance coverage, requires or pro-
 16 vides for a participant, beneficiary, or enrollee to
 17 designate a participating primary care provider—

18 (A) the plan or issuer shall permit such an
 19 individual who is a female to designate a par-
 20 ticipating physician who specializes in obstetrics
 21 and gynecology as the individual’s primary care
 22 provider; and

23 (B) if such an individual has not des-
 24 ignated such a provider as a primary care pro-
 25 vider, the plan or issuer—

1 (i) may not require authorization or a
2 referral by the individual's primary care
3 provider or otherwise for coverage of rou-
4 tine gynecological care (such as preventive
5 women's health examinations) and preg-
6 nancy-related services provided by a par-
7 ticipating health care professional who spe-
8 cializes in obstetrics and gynecology to the
9 extent such care is otherwise covered, and

10 (ii) may treat the ordering of other
11 gynecological care by such a participating
12 health professional as the authorization of
13 the primary care provider with respect to
14 such care under the plan or coverage.

15 (2) CONSTRUCTION.—Nothing in paragraph
16 (1)(B)(ii) shall waive any requirements of coverage
17 relating to medical necessity or appropriateness with
18 respect to coverage of gynecological care so ordered.

19 (b) SPECIALTY CARE.—

20 (1) SPECIALTY CARE FOR COVERED SERV-
21 ICES.—

22 (A) IN GENERAL.—If—

23 (i) an individual is a participant or
24 beneficiary under a group health plan or
25 an enrollee who is covered under health in-

1 insurance coverage offered by a health insur-
2 ance issuer,

3 (ii) the individual has a condition or
4 disease of sufficient seriousness and com-
5 plexity to require treatment by a specialist,
6 and

7 (iii) benefits for such treatment are
8 provided under the plan or coverage,

9 the plan or issuer shall make or provide for a
10 referral to a specialist who is available and ac-
11 cessible to provide the treatment for such condi-
12 tion or disease.

13 (B) SPECIALIST DEFINED.—For purposes
14 of this subsection, the term “specialist” means,
15 with respect to a condition, a health care practi-
16 tioner, facility, or center (such as a center of
17 excellence) that has adequate expertise through
18 appropriate training and experience (including,
19 in the case of a child, appropriate pediatric ex-
20 pertise) to provide high quality care in treating
21 the condition.

22 (C) CARE UNDER REFERRAL.—A group
23 health plan or health insurance issuer may re-
24 quire that the care provided to an individual

1 pursuant to such referral under subparagraph

2 (A) be—

3 (i) pursuant to a treatment plan, only
4 if the treatment plan is developed by the
5 specialist and approved by the plan or
6 issuer, in consultation with the designated
7 primary care provider or specialist and the
8 individual (or the individual's designee),
9 and

10 (ii) in accordance with applicable
11 quality assurance and utilization review
12 standards of the plan or issuer.

13 Nothing in this subsection shall be construed as
14 preventing such a treatment plan for an indi-
15 vidual from requiring a specialist to provide the
16 primary care provider with regular updates on
17 the specialty care provided, as well as all nec-
18 essary medical information.

19 (D) REFERRALS TO PARTICIPATING PRO-
20 VIDERS.—A group health plan or health insur-
21 ance issuer is not required under subparagraph
22 (A) to provide for a referral to a specialist that
23 is not a participating provider, unless the plan
24 or issuer does not have an appropriate specialist
25 that is available and accessible to treat the indi-

1 vidual's condition and that is a participating
2 provider with respect to such treatment.

3 (E) TREATMENT OF NONPARTICIPATING
4 PROVIDERS.—If a plan or issuer refers an indi-
5 vidual to a nonparticipating specialist pursuant
6 to subparagraph (A), services provided pursu-
7 ant to the approved treatment plan (if any)
8 shall be provided at no additional cost to the in-
9 dividual beyond what the individual would oth-
10 erwise pay for services received by such a spe-
11 cialist that is a participating provider.

12 (2) SPECIALISTS AS PRIMARY CARE PRO-
13 VIDERS.—

14 (A) IN GENERAL.—A group health plan, or
15 a health insurance issuer, in connection with
16 the provision of health insurance coverage, shall
17 have a procedure by which an individual who is
18 a participant, beneficiary, or enrollee and who
19 has an ongoing special condition (as defined in
20 subparagraph (C)) may receive a referral to a
21 specialist for such condition who shall be re-
22 sponsible for and capable of providing and co-
23 ordinating the individual's primary and spe-
24 cialty care. If such an individual's care would
25 most appropriately be coordinated by such a

1 specialist, such plan or issuer shall refer the in-
2 dividual to such specialist.

3 (B) TREATMENT AS PRIMARY CARE PRO-
4 VIDER.—Such specialist shall be permitted to
5 treat the individual without a referral from the
6 individual’s primary care provider and may au-
7 thorize such referrals, procedures, tests, and
8 other medical services as the individual’s pri-
9 mary care provider would otherwise be per-
10 mitted to provide or authorize, subject to the
11 terms of the treatment plan (referred to in
12 paragraph (1)(C)(i)).

13 (C) ONGOING SPECIAL CONDITION DE-
14 FINED.—In this paragraph, the term “special
15 condition” means a condition or disease that—

16 (i) is life-threatening, degenerative, or
17 disabling, and

18 (ii) requires specialized medical care
19 over a prolonged period of time.

20 (D) TERMS OF REFERRAL.—The provi-
21 sions of subparagraphs (C) through (E) of
22 paragraph (1) apply with respect to referrals
23 under subparagraph (A) of this paragraph in
24 the same manner as they apply to referrals
25 under paragraph (1)(A).

1 (3) STANDING REFERRALS.—

2 (A) IN GENERAL.—A group health plan,
3 and a health insurance issuer in connection
4 with the provision of health insurance coverage,
5 shall have a procedure by which an individual
6 who is a participant, beneficiary, or enrollee
7 and who has a condition that requires ongoing
8 care from a specialist may receive a standing
9 referral to such specialist for treatment of such
10 condition. If the plan or issuer, or if the pri-
11 mary care provider in consultation with the
12 medical director of the plan or issuer and the
13 specialist (if any), determines that such a
14 standing referral is appropriate, the plan or
15 issuer shall make such a referral to such a spe-
16 cialist.

17 (B) TERMS OF REFERRAL.—The provi-
18 sions of subparagraphs (C) through (E) of
19 paragraph (1) apply with respect to referrals
20 under subparagraph (A) of this paragraph in
21 the same manner as they apply to referrals
22 under paragraph (1)(A).

23 **SEC. ____105. CONTINUITY OF CARE.**

24 (a) IN GENERAL.—

1 (1) TERMINATION OF PROVIDER.—If a contract
2 between a group health plan, or a health insurance
3 issuer in connection with the provision of health in-
4 surance coverage, and a health care provider is ter-
5 minated (as defined in paragraph (3)), or benefits or
6 coverage provided by a health care provider are ter-
7 minated because of a change in the terms of pro-
8 vider participation in a group health plan, and an in-
9 dividual who is a participant, beneficiary, or enrollee
10 in the plan or coverage is undergoing a course of
11 treatment from the provider at the time of such ter-
12 mination, the plan or issuer shall—

13 (A) notify the individual on a timely basis
14 of such termination, and

15 (B) subject to subsection (c), permit the
16 individual to continue or be covered with re-
17 spect to the course of treatment with the pro-
18 vider during a transitional period (provided
19 under subsection (b)).

20 (2) TREATMENT OF TERMINATION OF CON-
21 TRACT WITH HEALTH INSURANCE ISSUER.—If a
22 contract for the provision of health insurance cov-
23 erage between a group health plan and a health in-
24 surance issuer is terminated and, as a result of such
25 termination, coverage of services of a health care

1 provider is terminated with respect to an individual,
2 the provisions of paragraph (1) (and the succeeding
3 provisions of this section) shall apply under the plan
4 in the same manner as if there had been a contract
5 between the plan and the provider that had been ter-
6 minated, but only with respect to benefits that are
7 covered under the plan after the contract termi-
8 nation.

9 (3) TERMINATION.—In this section, the term
10 “terminated” includes, with respect to a contract,
11 the expiration or nonrenewal of the contract, but
12 does not include a termination of the contract by the
13 plan or issuer for failure to meet applicable quality
14 standards or for fraud.

15 (b) TRANSITIONAL PERIOD.—

16 (1) IN GENERAL.—Except as provided in para-
17 graphs (2) through (4), the transitional period under
18 this subsection shall extend for at least 90 days from
19 the date of the notice described in subsection
20 (a)(1)(A) of the provider’s termination.

21 (2) INSTITUTIONAL CARE.—The transitional pe-
22 riod under this subsection for institutional or inpa-
23 tient care from a provider shall extend until the dis-
24 charge or termination of the period of institutional-
25 ization and also shall include institutional care pro-

1 vided within a reasonable time of the date of termi-
2 nation of the provider status if the care was sched-
3 uled before the date of the announcement of the ter-
4 mination of the provider status under subsection
5 (a)(1)(A) or if the individual on such date was on
6 an established waiting list or otherwise scheduled to
7 have such care.

8 (3) PREGNANCY.—If—

9 (A) a participant, beneficiary, or enrollee
10 has entered the second trimester of pregnancy
11 at the time of a provider’s termination of par-
12 ticipation, and

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

19 (4) TERMINAL ILLNESS.—If—

20 (A) a participant, beneficiary, or enrollee
21 was determined to be terminally ill (as deter-
22 mined under section 1861(dd)(3)(A) of the So-
23 cial Security Act) at the time of a provider’s
24 termination of participation, and

1 (B) the provider was treating the terminal
2 illness before the date of termination,
3 the transitional period under this subsection shall
4 extend for the remainder of the individual's life for
5 care directly related to the treatment of the terminal
6 illness.

7 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
8 group health plan or health insurance issuer may condi-
9 tion coverage of continued treatment by a provider under
10 subsection (a)(1)(B) upon the provider agreeing to the fol-
11 lowing terms and conditions:

12 (1) The provider agrees to accept reimburse-
13 ment from the plan or issuer and individual involved
14 (with respect to cost-sharing) at the rates applicable
15 prior to the start of the transitional period as pay-
16 ment in full (or, in the case described in subsection
17 (a)(2), at the rates applicable under the replacement
18 plan or issuer after the date of the termination of
19 the contract with the health insurance issuer) and
20 not to impose cost-sharing with respect to the indi-
21 vidual in an amount that would exceed the cost-shar-
22 ing that could have been imposed if the contract re-
23 ferred to in subsection (a)(1) had not been termi-
24 nated.

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

4 (B) subject to subsection (c), may not deny
5 (or limit or impose additional conditions on) the
6 coverage of routine patient costs for items and
7 services furnished in connection with participa-
8 tion in the trial; and

9 (C) may not discriminate against the indi-
10 vidual on the basis of the enrollee's participa-
11 tion in such trial.

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

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

1 (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-
2 poses of subsection (a), the term “qualified individual”
3 means an individual who is a participant or beneficiary
4 in a group health plan, or who is an enrollee under health
5 insurance coverage, and who meets the following condi-
6 tions:

7 (1)(A) The individual has a life-threatening or
8 serious illness for which no standard treatment is ef-
9 fective.

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

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

16 (2) Either—

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

23 (B) the participant, beneficiary, or enrollee
24 provides medical and scientific information es-
25 tablishing that the individual’s participation in

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

4 (c) PAYMENT.—

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

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

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

16 (B) a nonparticipating provider, the pay-
17 ment rate shall be at the rate the plan or issuer
18 would normally pay for comparable services
19 under subparagraph (A).

20 (d) APPROVED CLINICAL TRIAL DEFINED.—

21 (1) IN GENERAL.—In this section, the term
22 “approved clinical trial” means a clinical research
23 study or clinical investigation approved and funded
24 (which may include funding through in-kind con-
25 tributions) by one or more of the following:

1 (A) The National Institutes of Health.

2 (B) A cooperative group or center of the
3 National Institutes of Health.

4 (C) Either of the following if the condi-
5 tions described in paragraph (2) are met:

6 (i) The Department of Veterans Af-
7 fairs.

8 (ii) The Department of Defense.

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

15 (A) to be comparable to the system of peer
16 review of studies and investigations used by the
17 National Institutes of Health, and

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

21 (e) CONSTRUCTION.—Nothing in this section shall be
22 construed to limit a plan's or issuer's coverage with re-
23 spect to clinical trials.

1 **SEC. ____107. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

2 (a) IN GENERAL.—If a group health plan, or health
3 insurance issuer that offers health insurance coverage,
4 provides benefits with respect to prescription drugs but
5 the coverage limits such benefits to drugs included in a
6 formulary, the plan or issuer shall—

7 (1) ensure participation of participating physi-
8 cians and pharmacists in the development of the for-
9 mulary;

10 (2) disclose to providers and, disclose upon re-
11 quest under section ____121(c)(6) to participants,
12 beneficiaries, and enrollees, the nature of the for-
13 mulary restrictions; and

14 (3) consistent with the standards for a utiliza-
15 tion review program under section ____115, provide
16 for exceptions from the formulary limitation when a
17 non-formulary alternative is medically indicated.

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

20 (1) IN GENERAL.—A group health plan (or
21 health insurance coverage offered in connection with
22 such a plan) that provides any coverage of prescrip-
23 tion drugs or medical devices shall not deny coverage
24 of such a drug or device on the basis that the use
25 is investigational, if the use—

26 (A) in the case of a prescription drug—

1 (i) is included in the labeling author-
2 ized by the application in effect for the
3 drug pursuant to subsection (b) or (j) of
4 section 505 of the Federal Food, Drug,
5 and Cosmetic Act, without regard to any
6 postmarketing requirements that may
7 apply under such Act; or

8 (ii) is included in the labeling author-
9 ized by the application in effect for the
10 drug under section 351 of the Public
11 Health Service Act, without regard to any
12 postmarketing requirements that may
13 apply pursuant to such section; or

14 (B) in the case of a medical device, is in-
15 cluded in the labeling authorized by a regula-
16 tion under subsection (d) or (3) of section 513
17 of the Federal Food, Drug, and Cosmetic Act,
18 an order under subsection (f) of such section, or
19 an application approved under section 515 of
20 such Act, without regard to any postmarketing
21 requirements that may apply under such Act.

22 (2) CONSTRUCTION.—Nothing in this sub-
23 section shall be construed as requiring a group
24 health plan (or health insurance coverage offered in

1 connection with such a plan) to provide any coverage
2 of prescription drugs or medical devices.

3 **SEC. ___ 108. ADEQUACY OF PROVIDER NETWORK.**

4 (a) IN GENERAL.—Each group health plan, and each
5 health insurance issuer offering health insurance coverage,
6 that provides benefits, in whole or in part, through partici-
7 pating health care providers shall have (in relation to the
8 coverage) a sufficient number, distribution, and variety of
9 qualified participating health care providers to ensure that
10 all covered health care services, including specialty serv-
11 ices, will be available and accessible in a timely manner
12 to all participants, beneficiaries, and enrollees under the
13 plan or coverage. This subsection shall only apply to a
14 plan’s or issuer’s application of restrictions on the partici-
15 pation of health care providers in a network and shall not
16 be construed as requiring a plan or issuer to create or
17 establish new health care providers in an area.

18 (b) TREATMENT OF CERTAIN PROVIDERS.—The
19 qualified health care providers under subsection (a) may
20 include Federally qualified health centers, rural health
21 clinics, migrant health centers, and other essential com-
22 munity providers located in the service area of the plan
23 or issuer and shall include such providers if necessary to
24 meet the standards established to carry out such sub-
25 section.

1 **SEC. ____109. NONDISCRIMINATION IN DELIVERY OF SERV-**
 2 **ICES.**

3 (a) APPLICATION TO DELIVERY OF SERVICES.—Sub-
 4 ject to subsection (b), a group health plan, and health in-
 5 surance issuer in relation to health insurance coverage,
 6 may not discriminate against a participant, beneficiary, or
 7 enrollee in the delivery of health care services consistent
 8 with the benefits covered under the plan or coverage or
 9 as required by law based on race, color, ethnicity, national
 10 origin, religion, sex, age, mental or physical disability, sex-
 11 ual orientation, genetic information, or source of payment.

12 (b) CONSTRUCTION.—Nothing in subsection (a) shall
 13 be construed as relating to the eligibility to be covered,
 14 or the offering (or guaranteeing the offer) of coverage,
 15 under a plan or health insurance coverage, the application
 16 of any pre-existing condition exclusion consistent with ap-
 17 plicable law, or premiums charged under such plan or cov-
 18 erage. Pursuant to section ____192(b), except as provided
 19 in section ____152, nothing in this subtitle shall be con-
 20 strued as requiring a group health plan or health insur-
 21 ance issuer to provide specific benefits under the terms
 22 of such plan or coverage.

23 **CHAPTER 2—QUALITY ASSURANCE**

24 **SEC. ____111. INTERNAL QUALITY ASSURANCE PROGRAM.**

25 (a) REQUIREMENT.—A group health plan, and a
 26 health insurance issuer that offers health insurance cov-

1 erage, shall establish and maintain an ongoing, internal
2 quality assurance and continuous quality improvement
3 program that meets the requirements of subsection (b).

4 (b) PROGRAM REQUIREMENTS.—The requirements of
5 this subsection for a quality improvement program of a
6 plan or issuer are as follows:

7 (1) ADMINISTRATION.—The plan or issuer has
8 a separate identifiable unit with responsibility for
9 administration of the program.

10 (2) WRITTEN PLAN.—The plan or issuer has a
11 written plan for the program that is updated annu-
12 ally and that specifies at least the following:

13 (A) The activities to be conducted.

14 (B) The organizational structure.

15 (C) The duties of the medical director.

16 (D) Criteria and procedures for the assess-
17 ment of quality.

18 (3) SYSTEMATIC REVIEW.—The program pro-
19 vides for systematic review of the type of health
20 services provided, consistency of services provided
21 with good medical practice, and patient outcomes.

22 (4) QUALITY CRITERIA.—The program—

23 (A) uses criteria that are based on per-
24 formance and patient outcomes where feasible
25 and appropriate;

1 (B) includes criteria that are directed spe-
2 cifically at meeting the needs of at-risk popu-
3 lations and covered individuals with chronic
4 conditions or severe illnesses, including gender-
5 specific criteria and pediatric-specific criteria
6 where available and appropriate;

7 (C) includes methods for informing covered
8 individuals of the benefit of preventive care and
9 what specific benefits with respect to preventive
10 care are covered under the plan or coverage;
11 and

12 (D) makes available to the public a de-
13 scription of the criteria used under subpara-
14 graph (A).

15 (5) SYSTEM FOR REPORTING.—The program
16 has procedures for reporting of possible quality con-
17 cerns by providers and enrollees and for remedial ac-
18 tions to correct quality problems, including written
19 procedures for responding to concerns and taking
20 appropriate corrective action.

21 (6) DATA ANALYSIS.—The program provides,
22 using data that include the data collected under sec-
23 tion ____112, for an analysis of the plan's or
24 issuer's performance on quality measures.

1 (7) DRUG UTILIZATION REVIEW.—The program
2 provides for a drug utilization review program in ac-
3 cordance with section ____114.

4 (c) DEEMING.—For purposes of subsection (a), the
5 requirements of—

6 (1) subsection (b) (other than paragraph (5))
7 are deemed to be met with respect to a health insur-
8 ance issuer that is a qualified health maintenance
9 organization (as defined in section 1310(c) of the
10 Public Health Service Act); or

11 (2) subsection (b) are deemed to be met with
12 respect to a health insurance issuer that is accred-
13 ited by a national accreditation organization that the
14 Secretary certifies as applying, as a condition of cer-
15 tification, standards at least as stringent as those
16 required for a quality improvement program under
17 subsection (b).

18 (d) VARIATION PERMITTED.—The Secretary may
19 provide for variations in the application of the require-
20 ments of this section to group health plans and health in-
21 surance issuers based upon differences in the delivery sys-
22 tem among such plans and issuers as the Secretary deems
23 appropriate.

1 **SEC. ___112. COLLECTION OF STANDARDIZED DATA.**

2 (a) IN GENERAL.—A group health plan and a health
3 insurance issuer that offers health insurance coverage
4 shall collect uniform quality data that include a minimum
5 uniform data set described in subsection (b).

6 (b) MINIMUM UNIFORM DATA SET.—The Secretary
7 shall specify (and may from time to time update) the data
8 required to be included in the minimum uniform data set
9 under subsection (a) and the standard format for such
10 data. Such data shall include at least—

11 (1) aggregate utilization data;

12 (2) data on the demographic characteristics of
13 participants, beneficiaries, and enrollees;

14 (3) data on disease-specific and age-specific
15 mortality rates and (to the extent feasible) morbidity
16 rates of such individuals;

17 (4) data on satisfaction (including satisfaction
18 with respect to services to children) of such individ-
19 uals, including data on voluntary disenrollment and
20 grievances; and

21 (5) data on quality indicators and health out-
22 comes, including, to the extent feasible and appro-
23 priate, data on pediatric cases and on a gender-spe-
24 cific basis.

25 (c) AVAILABILITY.—A summary of the data collected
26 under subsection (a) shall be disclosed under section

1 ____121(b)(9). The Secretary shall be provided access to
2 all the data so collected.

3 (d) VARIATION PERMITTED.—The Secretary may
4 provide for variations in the application of the require-
5 ments of this section to group health plans and health in-
6 surance issuers based upon differences in the delivery sys-
7 tem among such plans and issuers as the Secretary deems
8 appropriate.

9 (e) EXCEPTION FOR NON-MEDICAL, RELIGIOUS
10 CARE PROVIDERS.—The requirements of subsection (a),
11 insofar as they may apply to a provider of health care,
12 do not apply to a provider that provides no medical care
13 and that provides only a religious method of healing or
14 religious nonmedical nursing care.

15 **SEC. ____113. PROCESS FOR SELECTION OF PROVIDERS.**

16 (a) IN GENERAL.—A group health plan and a health
17 insurance issuer that offers health insurance coverage
18 shall, if it provides benefits through participating health
19 care professionals, have a written process for the selection
20 of participating health care professionals, including min-
21 imum professional requirements.

22 (b) VERIFICATION OF BACKGROUND.—Such process
23 shall include verification of a health care provider’s license
24 and a history of suspension or revocation.

1 (c) RESTRICTION.—Such process shall not use a
2 high-risk patient base or location of a provider in an area
3 with residents with poorer health status as a basis for ex-
4 cluding providers from participation.

5 (d) NONDISCRIMINATION BASED ON LICENSURE.—

6 (1) IN GENERAL.—Such process shall not dis-
7 criminate with respect to participation or indem-
8 nification as to any provider who is acting within the
9 scope of the provider’s license or certification under
10 applicable State law, solely on the basis of such li-
11 cense or certification.

12 (2) CONSTRUCTION.—Paragraph (1) shall not
13 be construed—

14 (A) as requiring the coverage under a plan
15 or coverage of particular benefits or services or
16 to prohibit a plan or issuer from including pro-
17 viders only to the extent necessary to meet the
18 needs of the plan’s or issuer’s participants,
19 beneficiaries, or enrollees or from establishing
20 any measure designed to maintain quality and
21 control costs consistent with the responsibilities
22 of the plan or issuer; or

23 (B) to override any State licensure or
24 scope-of-practice law.

25 (e) GENERAL NONDISCRIMINATION.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 such process shall not discriminate with respect to
3 selection of a health care professional to be a partici-
4 pating health care provider, or with respect to the
5 terms and conditions of such participation, based on
6 the professional’s race, color, religion, sex, national
7 origin, age, sexual orientation, or disability (con-
8 sistent with the Americans with Disabilities Act of
9 1990).

10 (2) RULES.—The appropriate Secretary may
11 establish such definitions, rules, and exceptions as
12 may be appropriate to carry out paragraph (1), tak-
13 ing into account comparable definitions, rules, and
14 exceptions in effect under employment-based non-
15 discrimination laws and regulations that relate to
16 each of the particular bases for discrimination de-
17 scribed in such paragraph.

18 **SEC. ____ 114. DRUG UTILIZATION PROGRAM.**

19 A group health plan, and a health insurance issuer
20 that provides health insurance coverage, that includes ben-
21 efits for prescription drugs shall establish and maintain,
22 as part of its internal quality assurance and continuous
23 quality improvement program under section ____111, a
24 drug utilization program which—

1 (1) encourages appropriate use of prescription
2 drugs by participants, beneficiaries, and enrollees
3 and providers, and

4 (2) takes appropriate action to reduce the inci-
5 dence of improper drug use and adverse drug reac-
6 tions and interactions.

7 **SEC. ___115. STANDARDS FOR UTILIZATION REVIEW AC-**
8 **TIVITIES.**

9 (a) COMPLIANCE WITH REQUIREMENTS.—

10 (1) IN GENERAL.—A group health plan, and a
11 health insurance issuer that provides health insur-
12 ance coverage, shall conduct utilization review activi-
13 ties in connection with the provision of benefits
14 under such plan or coverage only in accordance with
15 a utilization review program that meets the require-
16 ments of this section.

17 (2) USE OF OUTSIDE AGENTS.—Nothing in this
18 section shall be construed as preventing a group
19 health plan or health insurance issuer from arrang-
20 ing through a contract or otherwise for persons or
21 entities to conduct utilization review activities on be-
22 half of the plan or issuer, so long as such activities
23 are conducted in accordance with a utilization review
24 program that meets the requirements of this section.

1 (3) UTILIZATION REVIEW DEFINED.—For pur-
2 poses of this section, the terms “utilization review”
3 and “utilization review activities” mean procedures
4 used to monitor or evaluate the clinical necessity,
5 appropriateness, efficacy, or efficiency of health care
6 services, procedures or settings, and includes pro-
7 spective review, concurrent review, second opinions,
8 case management, discharge planning, or retrospec-
9 tive review.

10 (b) WRITTEN POLICIES AND CRITERIA.—

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

15 (2) USE OF WRITTEN CRITERIA.—

16 (A) IN GENERAL.—Such a program shall
17 utilize written clinical review criteria developed
18 pursuant to the program with the input of ap-
19 propriate physicians. Such criteria shall include
20 written clinical review criteria described in sec-
21 tion ____111(b)(4)(B).

22 (B) CONTINUING USE OF STANDARDS IN
23 RETROSPECTIVE REVIEW.—If a health care
24 service has been specifically pre-authorized or
25 approved for an enrollee under such a program,

1 the program shall not, pursuant to retrospective
2 review, revise or modify the specific standards,
3 criteria, or procedures used for the utilization
4 review for procedures, treatment, and services
5 delivered to the enrollee during the same course
6 of treatment.

7 (c) CONDUCT OF PROGRAM ACTIVITIES.—

8 (1) ADMINISTRATION BY HEALTH CARE PRO-
9 FESSIONALS.—A utilization review program shall be
10 administered by qualified health care professionals
11 who shall oversee review decisions. In this sub-
12 section, the term “health care professional” means a
13 physician or other health care practitioner licensed,
14 accredited, or certified to perform specified health
15 services consistent with State law.

16 (2) USE OF QUALIFIED, INDEPENDENT PER-
17 SONNEL.—

18 (A) IN GENERAL.—A utilization review
19 program shall provide for the conduct of utiliza-
20 tion review activities only through personnel
21 who are qualified and, to the extent required,
22 who have received appropriate training in the
23 conduct of such activities under the program.

24 (B) PEER REVIEW OF SAMPLE OF AD-
25 VERSE CLINICAL DETERMINATIONS.—Such a

1 program shall provide that clinical peers (as de-
2 fined in section ____191(c)(2)) shall evaluate
3 the clinical appropriateness of at least a sample
4 of adverse clinical determinations.

5 (C) PROHIBITION OF CONTINGENT COM-
6 PENSATION ARRANGEMENTS.—Such a program
7 shall not, with respect to utilization review ac-
8 tivities, permit or provide compensation or any-
9 thing of value to its employees, agents, or con-
10 tractors in a manner that—

11 (i) provides incentives, direct or indi-
12 rect, for such persons to make inappro-
13 priate review decisions, or

14 (ii) is based, directly or indirectly, on
15 the quantity or type of adverse determina-
16 tions rendered.

17 (D) PROHIBITION OF CONFLICTS.—Such a
18 program shall not permit a health care profes-
19 sional who provides health care services to an
20 individual to perform utilization review activi-
21 ties in connection with the health care services
22 being provided to the individual.

23 (3) ACCESSIBILITY OF REVIEW.—Such a pro-
24 gram shall provide that appropriate personnel per-
25 forming utilization review activities under the pro-

1 gram are reasonably accessible by toll-free telephone
2 during normal business hours to discuss patient care
3 and allow response to telephone requests, and that
4 appropriate provision is made to receive and respond
5 promptly to calls received during other hours.

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

12 (5) LIMITATION ON INFORMATION REQUESTS.—
13 Under such a program, information shall be required
14 to be provided by health care providers only to the
15 extent it is necessary to perform the utilization re-
16 view activity involved.

17 (d) DEADLINE FOR DETERMINATIONS.—

18 (1) PRIOR AUTHORIZATION SERVICES.—Except
19 as provided in paragraph (2), in the case of a utili-
20 zation review activity involving the prior authoriza-
21 tion of health care items and services for an indi-
22 vidual, the utilization review program shall make a
23 determination concerning such authorization, and
24 provide notice of the determination to the individual
25 or the individual's designee and the individual's

1 health care provider by telephone and in printed
2 form, as soon as possible in accordance with the
3 medical exigencies of the cases, and in no event later
4 than 3 business days after the date of receipt of in-
5 formation that is reasonably necessary to make such
6 determination.

7 (2) CONTINUED CARE.—In the case of a utiliza-
8 tion review activity involving authorization for con-
9 tinued or extended health care services for an indi-
10 vidual, or additional services for an individual under-
11 going a course of continued treatment prescribed by
12 a health care provider, the utilization review pro-
13 gram shall make a determination concerning such
14 authorization, and provide notice of the determina-
15 tion to the individual or the individual's designee
16 and the individual's health care provider by tele-
17 phone and in printed form, as soon as possible in ac-
18 cordance with the medical exigencies of the cases,
19 and in no event later than 1 business day after the
20 date of receipt of information that is reasonably nec-
21 essary to make such determination. Such notice shall
22 include, with respect to continued or extended health
23 care services, the number of extended services ap-
24 proved, the new total of approved services, the date
25 of onset of services, and the next review date, if any.

1 (3) PREVIOUSLY PROVIDED SERVICES.—In the
2 case of a utilization review activity involving retro-
3 spective review of health care services previously pro-
4 vided for an individual, the utilization review pro-
5 gram shall make a determination concerning such
6 services, and provide notice of the determination to
7 the individual or the individual’s designee and the
8 individual’s health care provider by telephone and in
9 printed form, within 30 days of the date of receipt
10 of information that is reasonably necessary to make
11 such determination.

12 (4) REFERENCE TO SPECIAL RULES FOR EMER-
13 GENCY SERVICES, MAINTENANCE CARE, AND POST-
14 STABILIZATION CARE.—For waiver of prior author-
15 ization requirements in certain cases involving emer-
16 gency services and maintenance care and post-sta-
17 bilization care, see subsections (a)(1) and (b) of sec-
18 tion ____101, respectively.

19 (e) NOTICE OF ADVERSE DETERMINATIONS.—

20 (1) IN GENERAL.—Notice of an adverse deter-
21 mination under a utilization review program shall be
22 provided in printed form and shall include—

23 (A) the reasons for the determination (in-
24 cluding the clinical rationale);

1 (B) instructions on how to initiate an ap-
2 peal under section ____132; and

3 (C) notice of the availability, upon request
4 of the individual (or the individual's designee)
5 of the clinical review criteria relied upon to
6 make such determination.

7 (2) SPECIFICATION OF ANY ADDITIONAL INFOR-
8 MATION.—Such a notice shall also specify what (if
9 any) additional necessary information must be pro-
10 vided to, or obtained by, the person making the de-
11 termination in order to make a decision on such an
12 appeal.

13 **SEC. ____116. HEALTH CARE QUALITY ADVISORY BOARD.**

14 (a) ESTABLISHMENT.—The President shall establish
15 an advisory board to provide information to Congress and
16 the administration on issues relating to quality monitoring
17 and improvement in the health care provided under group
18 health plans and health insurance coverage.

19 (b) NUMBER AND APPOINTMENT.—The advisory
20 board shall be composed of the Secretary of Health and
21 Human Services (or the Secretary's designee), the Sec-
22 retary of Labor (or the Secretary's designee), and 20 addi-
23 tional members appointed by the President, in consulta-
24 tion with the Majority and Minority Leaders of the Senate

1 and House of Representatives. The members so appointed
2 shall include individuals with expertise in—

3 (1) consumer needs;

4 (2) education and training of health profes-
5 sionals;

6 (3) health care services;

7 (4) health plan management;

8 (5) health care accreditation, quality assurance,
9 improvement, measurement, and oversight;

10 (6) medical practice, including practicing physi-
11 cians;

12 (7) prevention and public health; and

13 (8) public and private group purchasing for
14 small and large employers or groups.

15 (c) DUTIES.—The advisory board shall—

16 (1) identify, update, and disseminate measures
17 of health care quality for group health plans and
18 health insurance issuers, including network and non-
19 network plans;

20 (2) advise the Secretary on the development
21 and maintenance of the minimum data set in section
22 ____112(b); and

23 (3) advise the Secretary on standardized for-
24 mats for information on group health plans and
25 health insurance coverage.

1 The measures identified under paragraph (1) may be used
2 on a voluntary basis by such plans and issuers. In carrying
3 out paragraph (1), the advisory board shall consult and
4 cooperate with national health care standard setting bod-
5 ies which define quality indicators, the Agency for Health
6 Care Policy and Research, the Institute of Medicine, and
7 other public and private entities that have expertise in
8 health care quality.

9 (d) REPORT.—The advisory board shall provide an
10 annual report to Congress and the President on the qual-
11 ity of the health care in the United States and national
12 and regional trends in health care quality. Such report
13 shall include a description of determinants of health care
14 quality and measurements of practice and quality varia-
15 bility within the United States.

16 (e) SECRETARIAL CONSULTATION.—In serving on
17 the advisory board, the Secretaries of Health and Human
18 Services and Labor (or their designees) shall consult with
19 the Secretaries responsible for other Federal health insur-
20 ance and health care programs.

21 (f) VACANCIES.—Any vacancy on the board shall be
22 filled in such manner as the original appointment. Mem-
23 bers of the board shall serve without compensation but
24 shall be reimbursed for travel, subsistence, and other nec-
25 essary expenses incurred by them in the performance of

1 their duties. Administrative support, scientific support,
2 and technical assistance for the advisory board shall be
3 provided by the Secretary of Health and Human Services.

4 (g) CONTINUATION.—Section 14(a)(2)(B) of the
5 Federal Advisory Committee Act (5 U.S.C. App.; relating
6 to the termination of advisory committees) shall not apply
7 to the advisory board.

8 CHAPTER 3—PATIENT INFORMATION

9 SEC. ___ 121. PATIENT INFORMATION.

10 (a) DISCLOSURE REQUIREMENT.—

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

13 (A) provide to participants and bene-
14 ficiaries at the time of initial coverage under
15 the plan (or the effective date of this section, in
16 the case of individuals who are participants or
17 beneficiaries as of such date), and at least an-
18 nually thereafter, the information described in
19 subsection (b) in printed form;

20 (B) provide to participants and bene-
21 ficiaries, within a reasonable period (as speci-
22 fied by the appropriate Secretary) before or
23 after the date of significant changes in the in-
24 formation described in subsection (b), informa-

1 tion in printed form on such significant
2 changes; and

3 (C) upon request, make available to par-
4 ticipants and beneficiaries, the applicable au-
5 thority, and prospective participants and bene-
6 ficiaries, the information described in sub-
7 section (b) or (c) in printed form.

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

11 (A) provide to individuals enrolled under
12 such coverage at the time of enrollment, and at
13 least annually thereafter, the information de-
14 scribed in subsection (b) in printed form;

15 (B) provide to enrollees, within a reason-
16 able period (as specified by the appropriate Sec-
17 retary) before or after the date of significant
18 changes in the information described in sub-
19 section (b), information in printed form on such
20 significant changes; and

21 (C) upon request, make available to the
22 applicable authority, to individuals who are pro-
23 spective enrollees, and to the public the infor-
24 mation described in subsection (b) or (c) in
25 printed form.

1 (b) INFORMATION PROVIDED.—The information de-
2 scribed in this subsection with respect to a group health
3 plan or health insurance coverage offered by a health in-
4 surance issuer includes the following:

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

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

9 (A) covered benefits, including benefit lim-
10 its and coverage exclusions;

11 (B) cost sharing, such as deductibles, coin-
12 surance, and copayment amounts, including any
13 liability for balance billing, any maximum limi-
14 tations on out of pocket expenses, and the max-
15 imum out of pocket costs for services that are
16 provided by nonparticipating providers or that
17 are furnished without meeting the applicable
18 utilization review requirements;

19 (C) the extent to which benefits may be ob-
20 tained from nonparticipating providers;

21 (D) the extent to which a participant, ben-
22 efiary, or enrollee may select from among par-
23 ticipating providers and the types of providers
24 participating in the plan or issuer network;

1 (E) process for determining experimental
2 coverage; and

3 (F) use of a prescription drug formulary.

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

5 (A) The number, mix, and distribution of
6 providers under the plan or coverage.

7 (B) Out-of-network coverage (if any) pro-
8 vided by the plan or coverage.

9 (C) Any point-of-service option (including
10 any supplemental premium or cost-sharing for
11 such option).

12 (D) The procedures for participants, bene-
13 ficiaries, and enrollees to select, access, and
14 change participating primary and specialty pro-
15 viders.

16 (E) The rights and procedures for obtain-
17 ing referrals (including standing referrals) to
18 participating and nonparticipating providers.

19 (F) The name, address, and telephone
20 number of participating health care providers
21 and an indication of whether each such provider
22 is available to accept new patients.

23 (G) Any limitations imposed on the selec-
24 tion of qualifying participating health care pro-

1 viders, including any limitations imposed under
2 section ____103(b)(2).

3 (H) How the plan or issuer addresses the
4 needs of participants, beneficiaries, and enroll-
5 ees and others who do not speak English or
6 who have other special communications needs in
7 accessing providers under the plan or coverage,
8 including the provision of information described
9 in this subsection and subsection (c) to such in-
10 dividuals and including the provision of infor-
11 mation in a language other than English if 5
12 percent of the number of participants, bene-
13 ficiaries, and enrollees communicate in that lan-
14 guage instead of English.

15 (4) OUT-OF-AREA COVERAGE.—Out-of-area cov-
16 erage provided by the plan or issuer.

17 (5) EMERGENCY COVERAGE.—Coverage of
18 emergency services, including—

19 (A) the appropriate use of emergency serv-
20 ices, including use of the 911 telephone system
21 or its local equivalent in emergency situations
22 and an explanation of what constitutes an
23 emergency situation;

24 (B) the process and procedures of the plan
25 or issuer for obtaining emergency services; and

1 (C) the locations of (i) emergency depart-
2 ments, and (ii) other settings, in which plan
3 physicians and hospitals provide emergency
4 services and post-stabilization care.

5 (6) PERCENTAGE OF PREMIUMS USED FOR
6 BENEFITS (LOSS-RATIOS).—In the case of health in-
7 surance coverage only (and not with respect to group
8 health plans that do not provide coverage through
9 health insurance coverage), a description of the over-
10 all loss-ratio for the coverage (as defined in accord-
11 ance with rules established or recognized by the Sec-
12 retary of Health and Human Services).

13 (7) PRIOR AUTHORIZATION RULES.—Rules re-
14 garding prior authorization or other review require-
15 ments that could result in noncoverage or non-
16 payment.

17 (8) GRIEVANCE AND APPEALS PROCEDURES.—
18 All appeal or grievance rights and procedures under
19 the plan or coverage, including the method for filing
20 grievances and the time frames and circumstances
21 for acting on grievances and appeals, who is the ap-
22 plicable authority with respect to the plan or issuer,
23 and the availability of assistance through an om-
24 budsman to individuals in relation to group health
25 plans and health insurance coverage.

1 (9) QUALITY ASSURANCE.—A summary descrip-
2 tion of the data on quality collected under section
3 ____112(a), including a summary description of the
4 data on satisfaction of participants, beneficiaries,
5 and enrollees (including data on individual voluntary
6 disenrollment and grievances and appeals) described
7 in section ____112(b)(4).

8 (10) SUMMARY OF PROVIDER FINANCIAL IN-
9 CENTIVES.—A summary description of the informa-
10 tion on the types of financial payment incentives
11 (described in section 1852(j)(4) of the Social Secu-
12 rity Act) provided by the plan or issuer under the
13 coverage.

14 (11) INFORMATION ON ISSUER.—Notice of ap-
15 propriate mailing addresses and telephone numbers
16 to be used by participants, beneficiaries, and enroll-
17 ees in seeking information or authorization for treat-
18 ment.

19 (12) AVAILABILITY OF INFORMATION ON RE-
20 QUEST.—Notice that the information described in
21 subsection (c) is available upon request.

22 (c) INFORMATION MADE AVAILABLE UPON RE-
23 QUEST.—The information described in this subsection is
24 the following:

1 (1) UTILIZATION REVIEW ACTIVITIES.—A de-
2 scription of procedures used and requirements (in-
3 cluding circumstances, time frames, and appeal
4 rights) under any utilization review program under
5 section ____115, including under any drug for-
6 mulary program under section ____107.

7 (2) GRIEVANCE AND APPEALS INFORMATION.—
8 Information on the number of grievances and ap-
9 peals and on the disposition in the aggregate of such
10 matters.

11 (3) METHOD OF PHYSICIAN COMPENSATION.—
12 An overall summary description as to the method of
13 compensation of participating physicians, including
14 information on the types of financial payment incen-
15 tives (described in section 1852(j)(4) of the Social
16 Security Act) provided by the plan or issuer under
17 the coverage.

18 (4) SPECIFIC INFORMATION ON CREDENTIALS
19 OF PARTICIPATING PROVIDERS.—In the case of each
20 participating provider, a description of the creden-
21 tials of the provider.

22 (5) CONFIDENTIALITY POLICIES AND PROCE-
23 DURES.—A description of the policies and proce-
24 dures established to carry out section ____122.

1 (6) FORMULARY RESTRICTIONS.—A description
2 of the nature of any drug formula restrictions.

3 (7) PARTICIPATING PROVIDER LIST.—A list of
4 current participating health care providers.

5 (d) FORM OF DISCLOSURE.—

6 (1) UNIFORMITY.—Information required to be
7 disclosed under this section shall be provided in ac-
8 cordance with uniform, national reporting standards
9 specified by the Secretary, after consultation with
10 applicable State authorities, so that prospective en-
11 rollees may compare the attributes of different
12 issuers and coverage offered within an area.

13 (2) INFORMATION INTO HANDBOOK.—Nothing
14 in this section shall be construed as preventing a
15 group health plan or health insurance issuer from
16 making the information under subsections (b) and
17 (c) available to participants, beneficiaries, and en-
18 rollees through an enrollee handbook or similar pub-
19 lication.

20 (3) UPDATING PARTICIPATING PROVIDER IN-
21 FORMATION.—The information on participating
22 health care providers described in subsection
23 (b)(3)(C) shall be updated within such reasonable
24 period as determined appropriate by the Secretary.
25 Nothing in this section shall prevent an issuer from

1 changing or updating other information made avail-
2 able under this section.

3 (e) CONSTRUCTION.—Nothing in this section shall be
4 construed as requiring public disclosure of individual con-
5 tracts or financial arrangements between a group health
6 plan or health insurance issuer and any provider.

7 **SEC. ___122. PROTECTION OF PATIENT CONFIDENTIALITY.**

8 Insofar as a group health plan, or a health insurance
9 issuer that offers health insurance coverage, maintains
10 medical records or other health information regarding par-
11 ticipants, beneficiaries, and enrollees, the plan or issuer
12 shall establish procedures—

13 (1) to safeguard the privacy of any individually
14 identifiable enrollee information;

15 (2) to maintain such records and information in
16 a manner that is accurate and timely, and

17 (3) to assure timely access of such individuals
18 to such records and information.

19 **SEC. ___123. HEALTH INSURANCE OMBUDSMEN.**

20 (a) IN GENERAL.—Each State that obtains a grant
21 under subsection (c) shall provide for creation and oper-
22 ation of a Health Insurance Ombudsman through a con-
23 tract with a not-for-profit organization that operates inde-
24 pendent of group health plans and health insurance

1 issuers. Such Ombudsman shall be responsible for at least
2 the following:

3 (1) To assist consumers in the State in choos-
4 ing among health insurance coverage or among cov-
5 erage options offered within group health plans.

6 (2) To provide counseling and assistance to en-
7 rollees dissatisfied with their treatment by health in-
8 surance issuers and group health plans in regard to
9 such coverage or plans and with respect to griev-
10 ances and appeals regarding determinations under
11 such coverage or plans.

12 (b) FEDERAL ROLE.—In the case of any State that
13 does not provide for such an Ombudsman under sub-
14 section (a), the Secretary shall provide for the creation
15 and operation of a Health Insurance Ombudsman through
16 a contract with a not-for-profit organization that operates
17 independent of group health plans and health insurance
18 issuers and that is responsible for carrying out with re-
19 spect to that State the functions otherwise provided under
20 subsection (a) by a Health Insurance Ombudsman.

21 (c) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to the Secretary of
23 Health and Human Services such amounts as may be nec-
24 essary to provide for grants to States for contracts for

1 Health Insurance Ombudsmen under subsection (a) or
2 contracts for such Ombudsmen under subsection (b).

3 (d) CONSTRUCTION.—Nothing in this section shall be
4 construed to prevent the use of other forms of enrollee
5 assistance.

6 CHAPTER 4—GRIEVANCE AND APPEALS

7 PROCEDURES

8 **SEC. ___131. ESTABLISHMENT OF GRIEVANCE PROCESS.**

9 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

10 (1) IN GENERAL.—A group health plan, and a
11 health insurance issuer in connection with the provi-
12 sion of health insurance coverage, shall establish and
13 maintain a system to provide for the presentation
14 and resolution of oral and written grievances
15 brought by individuals who are participants, bene-
16 ficiaries, or enrollees, or health care providers or
17 other individuals acting on behalf of an individual
18 and with the individual's consent, regarding any as-
19 pect of the plan's or issuer's services.

20 (2) SCOPE.—The system shall include griev-
21 ances regarding access to and availability of services,
22 quality of care, choice and accessibility of providers,
23 network adequacy, and compliance with the require-
24 ments of this subtitle.

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

4 (1) Written notification to all such individuals
 5 and providers of the telephone numbers and business
 6 addresses of the plan or issuer personnel responsible
 7 for resolution of grievances and appeals.

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

11 (3) A process providing for timely processing
 12 and resolution of grievances.

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

16 (5) Notification to the continuous quality im-
 17 provement program under section ____111(a) of all
 18 grievances and appeals relating to quality of care.

19 **SEC. ____132. INTERNAL APPEALS OF ADVERSE DETER-**
 20 **MINATIONS.**

21 (a) RIGHT OF APPEAL.—

22 (1) IN GENERAL.—A participant or beneficiary
 23 in a group health plan, and an enrollee in health in-
 24 surance coverage offered by a health insurance
 25 issuer, and any provider or other person acting on

1 behalf of such an individual with the individual's
2 consent, may appeal any appealable decision (as de-
3 fined in paragraph (2)) under the procedures de-
4 scribed in this section and (to the extent applicable)
5 section ____133. Such individuals and providers
6 shall be provided with a written explanation of the
7 appeal process and the determination upon the con-
8 clusion of the appeals process and as provided in
9 section ____121(b)(8).

10 (2) APPEALABLE DECISION DEFINED.—In this
11 section, the term “appealable decision” means any of
12 the following:

13 (A) Denial, reduction, or termination of, or
14 failure to provide or make payment (in whole or
15 in part) for a benefit, including a failure to
16 cover an item or service for which benefits are
17 otherwise provided because it is determined to
18 be experimental or investigational or not medi-
19 cally necessary or appropriate.

20 (B) Failure to provide coverage of emer-
21 gency services or reimbursement of mainte-
22 nance care or post-stabilization care under sec-
23 tion ____101.

24 (C) Failure to provide a choice of provider
25 under section ____103.

1 (D) Failure to provide qualified health care
2 providers under section ____103.

3 (E) Failure to provide access to specialty
4 and other care under section ____104.

5 (F) Failure to provide continuation of care
6 under section ____105.

7 (G) Failure to provide coverage of routine
8 patient costs in connection with an approval
9 clinical trial under section ____106.

10 (H) Failure to provide access to needed
11 drugs under section ____107(a)(3) or 107(b).

12 (I) Discrimination in delivery of services in
13 violation of section ____109.

14 (J) An adverse determination under a utili-
15 zation review program under section ____115.

16 (K) The imposition of a limitation that is
17 prohibited under section ____151.

18 (b) INTERNAL APPEAL PROCESS.—

19 (1) IN GENERAL.—Each group health plan and
20 health insurance issuer shall establish and maintain
21 an internal appeal process under which any partici-
22 pant, beneficiary, or enrollee, or any provider or
23 other person acting on behalf of such an individual
24 with the individual's consent, who is dissatisfied with
25 any appealable decision has the opportunity to ap-

1 peal the decision through an internal appeal process.

2 The appeal may be communicated orally.

3 (2) CONDUCT OF REVIEW.—

4 (A) IN GENERAL.—The process shall in-
5 clude a review of the decision by a physician or
6 other health care professional (or professionals)
7 who has been selected by the plan or issuer and
8 who has not been involved in the appealable de-
9 cision at issue in the appeal.

10 (B) AVAILABILITY AND PARTICIPATION OF
11 CLINICAL PEERS.—The individuals conducting
12 such review shall include one or more clinical
13 peers (as defined in section ____191(c)(2)) who
14 have not been involved in the appealable deci-
15 sion at issue in the appeal.

16 (3) DEADLINE.—

17 (A) IN GENERAL.—Subject to subsection
18 (c), the plan or issuer shall conclude each ap-
19 peal as soon as possible after the time of the re-
20 ceipt of the appeal in accordance with medical
21 exigencies of the case involved, but in no event
22 later than—

23 (i) 72 hours after the time of receipt
24 of an expedited appeal, and

1 (ii) except as provided in subpara-
2 graph (B), 30 business days after such
3 time (or, if the participant, beneficiary, or
4 enrollee supplies additional information
5 that was not available to the plan or issuer
6 at the time of the receipt of the appeal,
7 after the date of supplying such additional
8 information) in the case of all other ap-
9 peals.

10 (B) EXTENSION.—In the case of an appeal
11 that does not relate to a decision regarding an
12 expedited appeal and that does not involve med-
13 ical exigencies, if a group health plan or health
14 insurance issuer is unable to conclude the ap-
15 peal within the time period provided under sub-
16 paragraph (A)(ii) due to circumstances beyond
17 the control of the plan or issuer, the deadline
18 shall be extended for up to an additional 10
19 business days if the plan or issuer provides, on
20 or before 10 days before the deadline otherwise
21 applicable, written notice to the participant,
22 beneficiary, or enrollee and the provider in-
23 volved of the extension and the reasons for the
24 extension.

1 (4) NOTICE.—If a plan or issuer denies an ap-
2 peal, the plan or issuer shall provide the participant,
3 beneficiary, or enrollee and provider involved with
4 notice in printed form of the denial and the reasons
5 therefore, together with a notice in printed form of
6 rights to any further appeal.

7 (c) EXPEDITED REVIEW PROCESS.—

8 (1) IN GENERAL.—A group health plan, and a
9 health insurance issuer, shall establish procedures in
10 writing for the expedited consideration of appeals
11 under subsection (b) in situations in which the appli-
12 cation of the normal timeframe for making a deter-
13 mination could seriously jeopardize the life or health
14 of the participant, beneficiary, or enrollee (including
15 in the case of a child, development) or such an indi-
16 vidual's ability to regain maximum function.

17 (2) PROCESS.—Under such procedures—

18 (A) the request for expedited appeal may
19 be submitted orally or in writing by an indi-
20 vidual or provider who is otherwise entitled to
21 request the appeal; and

22 (B) all necessary information, including
23 the plan's or issuer's decision, shall be trans-
24 mitted between the plan or issuer and the re-

1 quester by telephone, facsimile, or other simi-
2 larly expeditious available method.

3 (d) **DIRECT USE OF FURTHER APPEALS.**—In the
4 event that the plan or issuer fails to comply with any of
5 the deadlines for completion of appeals under this section
6 or in the event that the plan or issuer for any reason ex-
7 pressly waives its rights to an internal review of an appeal
8 under subsection (b), the participant, beneficiary, or en-
9 rollee involved and the provider involved shall be relieved
10 of any obligation to complete the appeal involved and may,
11 at such an individual's or provider's option, proceed di-
12 rectly to seek further appeal through any applicable exter-
13 nal appeals process.

14 **SEC. ___133. EXTERNAL APPEALS OF ADVERSE DETER-**
15 **MINATIONS.**

16 (a) **RIGHT TO EXTERNAL APPEAL.**—

17 (1) **IN GENERAL.**—A group health plan, and a
18 health insurance issuer offering group health insur-
19 ance coverage, shall provide for an external appeals
20 process that meets the requirements of this section
21 in the case of an externally appealable decision de-
22 scribed in paragraph (2). The appropriate Secretary
23 shall establish standards to carry out such require-
24 ments.

1 (2) EXTERNALLY APPEALABLE DECISION DE-
 2 FINED.—For purposes of this section, the term “ex-
 3 ternally appealable decision” means an appealable
 4 decision (as defined in section ____132(a)(2)) if—

5 (A) the amount involved exceeds a signifi-
 6 cant threshold; or

7 (B) the patient’s life or health is jeopard-
 8 ized (including, in the case of a child, develop-
 9 ment) as a consequence of the decision.

10 Such term does not include a denial of coverage for
 11 services that are specifically listed in plan or cov-
 12 erage documents as excluded from coverage.

13 (3) EXHAUSTION OF INTERNAL APPEALS PROC-
 14 ESS.—A plan or issuer may condition the use of an
 15 external appeal process in the case of an externally
 16 appealable decision upon completion of the internal
 17 review process provided under section ____132, but
 18 only if the decision is made in a timely basis con-
 19 sistent with the deadlines provided under this chap-
 20 ter.

21 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS
 22 PROCESS.—

23 (1) CONTRACT WITH QUALIFIED EXTERNAL AP-
 24 PEAL ENTITY.—

1 (A) CONTRACT REQUIREMENT.—Subject to
2 subparagraph (B), the external appeal process
3 under this section of a plan or issuer shall be
4 conducted under a contract between the plan or
5 issuer and one or more qualified external appeal
6 entities (as defined in subsection (c)).

7 (B) RESTRICTIONS ON QUALIFIED EXTER-
8 NAL APPEAL ENTITY.—

9 (i) BY STATE FOR HEALTH INSUR-
10 ANCE ISSUERS.—With respect to health in-
11 surance issuers in a State, the State may
12 provide for external review activities to be
13 conducted by a qualified external appeal
14 entity that is designated by the State or
15 that is selected by the State in such a
16 manner as to assure an unbiased deter-
17 mination.

18 (ii) BY FEDERAL GOVERNMENT FOR
19 GROUP HEALTH PLANS.—With respect to
20 group health plans, the appropriate Sec-
21 retary may exercise the same authority as
22 a State may exercise with respect to health
23 insurance issuers under clause (i). Such
24 authority may include requiring the use of

1 the qualified external appeal entity des-
2 ignated or selected under such clause.

3 (iii) LIMITATION ON PLAN OR ISSUER
4 SELECTION.—If an applicable authority
5 permits more than one entity to qualify as
6 a qualified external appeal entity with re-
7 spect to a group health plan or health in-
8 surance issuer and the plan or issuer may
9 select among such qualified entities, the
10 applicable authority—

11 (I) shall assure that the selection
12 process will not create any incentives
13 for external appeal entities to make a
14 decision in a biased manner, and

15 (II) shall implement procedures
16 for auditing a sample of decisions by
17 such entities to assure that no such
18 decisions are made in a biased man-
19 ner.

20 (C) OTHER TERMS AND CONDITIONS.—

21 The terms and conditions of a contract under
22 this paragraph shall be consistent with the
23 standards the appropriate Secretary shall estab-
24 lish to assure there is no real or apparent con-
25 flict of interest in the conduct of external ap-

1 peal activities. Such contract shall provide that
2 the direct costs of the process (not including
3 costs of representation of a participant, bene-
4 ficiary, or enrollee) shall be paid by the plan
5 or issuer, and not by the participant, bene-
6 ficiary, or enrollee.

7 (2) ELEMENTS OF PROCESS.—An external ap-
8 peal process shall be conducted consistent with
9 standards established by the appropriate Secretary
10 that include at least the following:

11 (A) FAIR PROCESS; DE NOVO DETERMINA-
12 TION.—The process shall provide for a fair, de
13 novo determination.

14 (B) DETERMINATION CONCERNING EXTER-
15 NALLY APPEALABLE DECISIONS.—A qualified
16 external appeal entity shall determine whether a
17 decision is an externally appealable decision and
18 related decisions, including—

19 (i) whether such a decision involves an
20 expedited appeal;

21 (ii) the appropriate deadlines for in-
22 ternal review process required due to med-
23 ical exigencies in a case; and

24 (iii) whether such a process has been
25 completed.

1 (C) OPPORTUNITY TO SUBMIT EVIDENCE,
2 HAVE REPRESENTATION, AND MAKE ORAL
3 PRESENTATION.—Each party to an externally
4 appealable decision—

5 (i) may submit and review evidence
6 related to the issues in dispute,

7 (ii) may use the assistance or rep-
8 resentation of one or more individuals (any
9 of whom may be an attorney), and

10 (iii) may make an oral presentation.

11 (D) PROVISION OF INFORMATION.—The
12 plan or issuer involved shall provide timely ac-
13 cess to all its records relating to the matter of
14 the externally appealable decision and to all
15 provisions of the plan or health insurance cov-
16 erage (including any coverage manual) relating
17 to the matter.

18 (E) TIMELY DECISIONS.—A determination
19 by the external appeal entity on the decision
20 shall—

21 (i) be made orally or in writing and,
22 if it is made orally, shall be supplied to the
23 parties in writing as soon as possible;

24 (ii) be binding on the plan or issuer;

1 (iii) be made in accordance with the
2 medical exigencies of the case involved, but
3 in no event later than 60 days (or 72
4 hours in the case of an expedited appeal)
5 from the date of completion of the filing of
6 notice of external appeal of the decision;

7 (iv) state, in layperson's language, the
8 basis for the determination, including, if
9 relevant, any basis in the terms or condi-
10 tions of the plan or coverage; and

11 (v) inform the participant, beneficiary,
12 or enrollee of the individual's rights to seek
13 further review by the courts (or other proc-
14 ess) of the external appeal determination.

15 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-
16 TIES.—

17 (1) IN GENERAL.—For purposes of this section,
18 the term “qualified external appeal entity” means,
19 in relation to a plan or issuer, an entity (which may
20 be a governmental entity) that is certified under
21 paragraph (2) as meeting the following require-
22 ments:

23 (A) There is no real or apparent conflict of
24 interest that would impede the entity con-

1 ducting external appeal activities independent
2 of the plan or issuer.

3 (B) The entity conducts external appeal
4 activities through clinical peers.

5 (C) The entity has sufficient medical, legal,
6 and other expertise and sufficient staffing to
7 conduct external appeal activities for the plan
8 or issuer on a timely basis consistent with sub-
9 section (b)(3)(E).

10 (D) The entity meets such other require-
11 ments as the appropriate Secretary may im-
12 pose.

13 (2) CERTIFICATION OF EXTERNAL APPEAL EN-
14 TITIES.—

15 (A) IN GENERAL.—In order to be treated
16 as a qualified external appeal entity with re-
17 spect to—

18 (i) a group health plan, the entity
19 must be certified (and, in accordance with
20 subparagraph (B), periodically recertified)
21 as meeting the requirements of paragraph
22 (1) by the Secretary of Labor (or under a
23 process recognized or approved by the Sec-
24 retary of Labor); or

1 (ii) a health insurance issuer oper-
2 ating in a State, the entity must be cer-
3 tified (and, in accordance with subpara-
4 graph (B), periodically recertified) as
5 meeting such requirements by the applica-
6 ble State authority (or, if the State has not
7 established an adequate certification and
8 recertification process, by the Secretary of
9 Health and Human Services, or under a
10 process recognized or approved by such
11 Secretary).

12 (B) RECERTIFICATION PROCESS.—The ap-
13 propriate Secretary shall develop standards for
14 the recertification of external appeal entities.
15 Such standards shall include a specification
16 of—

17 (i) the information required to be sub-
18 mitted as a condition of recertification on
19 the entity’s performance of external appeal
20 activities, which information shall include
21 the number of cases reviewed, a summary
22 of the disposition of those cases, the length
23 of time in making determinations on those
24 cases, and such information as may be nec-
25 essary to assure the independence of the

1 entity from the plans or issuers for which
 2 external appeal activities are being con-
 3 ducted; and

4 (ii) the periodicity which recertifi-
 5 cation will be required.

6 (d) CONTINUING LEGAL RIGHTS OF ENROLLEES.—
 7 Nothing in this subtitle shall be construed as removing
 8 any legal rights of participants, beneficiaries, enrollees,
 9 and others under State or Federal law, including the right
 10 to file judicial actions to enforce rights.

11 CHAPTER 5—PROTECTING THE DOCTOR-
 12 PATIENT RELATIONSHIP

13 **SEC. ____141. PROHIBITION OF INTERFERENCE WITH CER-**
 14 **TAIN MEDICAL COMMUNICATIONS.**

15 (a) PROHIBITION.—

16 (1) GENERAL RULE.—The provisions of any
 17 contract or agreement, or the operation of any con-
 18 tract or agreement, between a group health plan or
 19 health insurance issuer in relation to health insur-
 20 ance coverage (including any partnership, associa-
 21 tion, or other organization that enters into or ad-
 22 ministers such a contract or agreement) and a
 23 health care provider (or group of health care pro-
 24 viders) shall not prohibit or restrict the provider

1 from engaging in medical communications with the
2 provider's patient.

3 (2) NULLIFICATION.—Any contract provision or
4 agreement that restricts or prohibits medical com-
5 munications in violation of paragraph (1) shall be
6 null and void.

7 (b) RULES OF CONSTRUCTION.—Nothing in this sec-
8 tion shall be construed—

9 (1) to prohibit the enforcement, as part of a
10 contract or agreement to which a health care pro-
11 vider is a party, of any mutually agreed upon terms
12 and conditions, including terms and conditions re-
13 quiring a health care provider to participate in, and
14 cooperate with, all programs, policies, and proce-
15 dures developed or operated by a group health plan
16 or health insurance issuer to assure, review, or im-
17 prove the quality and effective utilization of health
18 care services (if such utilization is according to
19 guidelines or protocols that are based on clinical or
20 scientific evidence and the professional judgment of
21 the provider) but only if the guidelines or protocols
22 under such utilization do not prohibit or restrict
23 medical communications between providers and their
24 patients; or

1 (2) to permit a health care provider to mis-
2 represent the scope of benefits covered under the
3 group health plan or health insurance coverage or to
4 otherwise require a group health plan health insur-
5 ance issuer to reimburse providers for benefits not
6 covered under the plan or coverage.

7 (c) MEDICAL COMMUNICATION DEFINED.—In this
8 section:

9 (1) IN GENERAL.—The term “medical commu-
10 nication” means any communication made by a
11 health care provider with a patient of the health care
12 provider (or the guardian or legal representative of
13 such patient) with respect to—

14 (A) the patient’s health status, medical
15 care, or treatment options;

16 (B) any utilization review requirements
17 that may affect treatment options for the pa-
18 tient; or

19 (C) any financial incentives that may af-
20 fect the treatment of the patient.

21 (2) MISREPRESENTATION.—The term “medical
22 communication” does not include a communication
23 by a health care provider with a patient of the
24 health care provider (or the guardian or legal rep-
25 resentative of such patient) if the communication in-

1 volves a knowing or willful misrepresentation by
2 such provider.

3 **SEC. ___ 142. PROHIBITION AGAINST TRANSFER OF INDEM-**
4 **NIFICATION OR IMPROPER INCENTIVE AR-**
5 **RANGEMENTS.**

6 (a) PROHIBITION OF TRANSFER OF INDEMNIFICA-
7 TION.—

8 (1) IN GENERAL.—No contract or agreement
9 between a group health plan or health insurance
10 issuer (or any agent acting on behalf of such a plan
11 or issuer) and a health care provider shall contain
12 any provision purporting to transfer to the health
13 care provider by indemnification or otherwise any li-
14 ability relating to activities, actions, or omissions of
15 the plan, issuer, or agent (as opposed to the pro-
16 vider).

17 (2) NULLIFICATION.—Any contract or agree-
18 ment provision described in paragraph (1) shall be
19 null and void.

20 (b) PROHIBITION OF IMPROPER PHYSICIAN INCEN-
21 TIVE PLANS.—

22 (1) IN GENERAL.—A group health plan and a
23 health insurance issuer offering health insurance
24 coverage may not operate any physician incentive
25 plan (as defined in subparagraph (B) of section

1 1876(i)(8) of the Social Security Act) unless the re-
 2 quirements described in subparagraph (A) of such
 3 section are met with respect to such a plan.

4 (2) APPLICATION.—For purposes of carrying
 5 out paragraph (1), any reference in section
 6 1876(i)(8) of the Social Security Act to the Sec-
 7 retary, an eligible organization, or an individual en-
 8 rolled with the organization shall be treated as a ref-
 9 erence to the applicable authority, a group health
 10 plan or health insurance issuer, respectively, and a
 11 participant, beneficiary, or enrollee with the plan or
 12 organization, respectively.

13 **SEC. ___143. ADDITIONAL RULES REGARDING PARTICIPA-**
 14 **TION OF HEALTH CARE PROFESSIONALS.**

15 (a) PROCEDURES.—Insofar as a group health plan,
 16 or health insurance issuer that offers health insurance cov-
 17 erage, provides benefits through participating health care
 18 professionals, the plan or issuer shall establish reasonable
 19 procedures relating to the participation (under an agree-
 20 ment between a professional and the plan or issuer) of
 21 such professionals under the plan or coverage. Such proce-
 22 dures shall include—

23 (1) providing notice of the rules regarding par-
 24 ticipation;

1 (2) providing written notice of participation de-
2 cisions that are adverse to professionals; and

3 (3) providing a process within the plan or issuer
4 for appealing such adverse decisions, including the
5 presentation of information and views of the profes-
6 sional regarding such decision.

7 (b) CONSULTATION IN MEDICAL POLICIES.—A group
8 health plan, and health insurance issuer that offers health
9 insurance coverage, shall consult with participating physi-
10 cians (if any) regarding the plan’s or issuer’s medical pol-
11 icy, quality, and medical management procedures.

12 **SEC. ___ 144. PROTECTION FOR PATIENT ADVOCACY.**

13 (a) PROTECTION FOR USE OF UTILIZATION REVIEW
14 AND GRIEVANCE PROCESS.—A group health plan, and a
15 health insurance issuer with respect to the provision of
16 health insurance coverage, may not retaliate against a par-
17 ticipant, beneficiary, enrollee, or health care provider
18 based on the participant’s, beneficiary’s, enrollee’s or pro-
19 vider’s use of, or participation in, a utilization review proc-
20 ess or a grievance process of the plan or issuer (including
21 an internal or external review or appeal process) under
22 this subtitle.

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

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

5 (A) discloses information relating to the
6 care, services, or conditions affecting one or
7 more participants, beneficiaries, or enrollees of
8 the plan or issuer to an appropriate public reg-
9 ulatory agency, an appropriate private accredi-
10 tation body, or appropriate management per-
11 sonnel of the plan or issuer; or

12 (B) initiates, cooperates, or otherwise par-
13 ticipates in an investigation or proceeding by
14 such an agency with respect to such care, serv-
15 ices, or conditions.

16 If an institutional health care provider is a partici-
17 pating provider with such a plan or issuer or other-
18 wise receives payments for benefits provided by such
19 a plan or issuer, the provisions of the previous sen-
20 tence shall apply to the provider in relation to care,
21 services, or conditions affecting one or more patients
22 within an institutional health care provider in the
23 same manner as they apply to the plan or issuer in
24 relation to care, services, or conditions provided to
25 one or more participants, beneficiaries, or enrollees;

1 and for purposes of applying this sentence, any ref-
2 erence to a plan or issuer is deemed a reference to
3 the institutional health care provider.

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

10 (A) the disclosure is made on the basis of
11 personal knowledge and is consistent with that
12 degree of learning and skill ordinarily possessed
13 by health care professionals with the same li-
14 censure or certification and the same experi-
15 ence;

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

18 (C) the information evidences either a vio-
19 lation of a law, rule, or regulation, of an appli-
20 cable accreditation standard, or of a generally
21 recognized professional or clinical standard or
22 that a patient is in imminent hazard of loss of
23 life or serious injury; and

24 (D) subject to subparagraphs (B) and (C)
25 of paragraph (3), the professional has followed

1 reasonable internal procedures of the plan,
2 issuer, or institutional health care provider es-
3 tablished for the purpose of addressing quality
4 concerns before making the disclosure.

5 (3) EXCEPTION AND SPECIAL RULE.—

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

12 (B) NOTICE OF INTERNAL PROCEDURES.—
13 Subparagraph (D) of paragraph (2) shall not
14 apply unless the internal procedures involved
15 are reasonably expected to be known to the
16 health care professional involved. For purposes
17 of this subparagraph, a health care professional
18 is reasonably expected to know of internal pro-
19 cedures if those procedures have been made
20 available to the professional through distribu-
21 tion or posting.

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

1 (i) the disclosure relates to an immi-
2 nent hazard of loss of life or serious injury
3 to a patient;

4 (ii) the disclosure is made to an ap-
5 propriate private accreditation body pursu-
6 ant to disclosure procedures established by
7 the body; or

8 (iii) the disclosure is in response to an
9 inquiry made in an investigation or pro-
10 ceeding of an appropriate public regulatory
11 agency and the information disclosed is
12 limited to the scope of the investigation or
13 proceeding.

14 (4) ADDITIONAL CONSIDERATIONS.—It shall
15 not be a violation of paragraph (1) to take an ad-
16 verse action against a protected health care profes-
17 sional if the plan, issuer, or provider taking the ad-
18 verse action involved demonstrates that it would
19 have taken the same adverse action even in the ab-
20 sence of the activities protected under such para-
21 graph.

22 (5) NOTICE.—A group health plan, health in-
23 surance issuer, and institutional health care provider
24 shall post a notice, to be provided or approved by
25 the Secretary of Labor, setting forth excerpts from,

1 or summaries of, the pertinent provisions of this
2 subsection and information pertaining to enforce-
3 ment of such provisions.

4 (6) CONSTRUCTIONS.—

5 (A) DETERMINATIONS OF COVERAGE.—

6 Nothing in this subsection shall be construed to
7 prohibit a plan or issuer from making a deter-
8 mination not to pay for a particular medical
9 treatment or service or the services of a type of
10 health care professional.

11 (B) ENFORCEMENT OF PEER REVIEW PRO-

12 TOCOLS AND INTERNAL PROCEDURES.—Noth-
13 ing in this subsection shall be construed to pro-
14 hibit a plan, issuer, or provider from estab-
15 lishing and enforcing reasonable peer review or
16 utilization review protocols or determining
17 whether a protected health care professional has
18 complied with those protocols or from estab-
19 lishing and enforcing internal procedures for
20 the purpose of addressing quality concerns.

21 (C) RELATION TO OTHER RIGHTS.—Noth-

22 ing in this subsection shall be construed to
23 abridge rights of participants, beneficiaries, en-
24 rollees, and protected health care professionals
25 under other applicable Federal or State laws.

1 in which particular services are delivered if the serv-
2 ices are medically necessary or appropriate for treat-
3 ment or diagnosis to the extent that such treatment
4 or diagnosis is otherwise a covered benefit.

5 (2) CONSTRUCTION.—Paragraph (1) shall not
6 be construed as prohibiting a plan or issuer from
7 limiting the delivery of services to one or more
8 health care providers within a network of such pro-
9 viders.

10 (3) MANNER OR SETTING DEFINED.—In para-
11 graph (1), the term “manner or setting” means the
12 location of treatment, such as whether treatment is
13 provided on an inpatient or outpatient basis, and the
14 duration of treatment, such as the number of days
15 in a hospital. Such term does not include the cov-
16 erage of a particular service or treatment.

17 (b) NO CHANGE IN COVERAGE.—Subsection (a) shall
18 not be construed as requiring coverage of particular serv-
19 ices the coverage of which is otherwise not covered under
20 the terms of the plan or coverage or from conducting utili-
21 zation review activities consistent with this subsection.

22 (c) MEDICAL NECESSITY OR APPROPRIATENESS DE-
23 FINED.—In subsection (a), the term “medically necessary
24 or appropriate” means, with respect to a service or benefit,

1 a service or benefit which is consistent with generally ac-
2 cepted principles of professional medical practice.

3 **SEC. ___152. STANDARDS RELATING TO BENEFITS FOR**
4 **CERTAIN BREAST CANCER TREATMENT.**

5 (a) INPATIENT CARE.—

6 (1) IN GENERAL.—A group health plan, and a
7 health insurance issuer offering group health insur-
8 ance coverage, that provides medical and surgical
9 benefits shall ensure that inpatient coverage with re-
10 spect to the treatment of breast cancer is provided
11 for a period of time as is determined by the attend-
12 ing physician, in his or her professional judgment
13 consistent with generally accepted medical stand-
14 ards, in consultation with the patient, to be medi-
15 cally appropriate following—

16 (A) a mastectomy;

17 (B) a lumpectomy; or

18 (C) a lymph node dissection for the treat-
19 ment of breast cancer.

20 (2) EXCEPTION.—Nothing in this section shall
21 be construed as requiring the provision of inpatient
22 coverage if the attending physician and patient de-
23 termine that a shorter period of hospital stay is
24 medically appropriate.

1 (b) PROHIBITIONS.—A group health plan, and a
2 health insurance issuer offering group health insurance
3 coverage in connection with a group health plan, may
4 not—

5 (1) deny to a woman eligibility, or continued
6 eligibility, to enroll or to renew coverage under the
7 terms of the plan, solely for the purpose of avoiding
8 the requirements of this section;

9 (2) provide monetary payments or rebates to
10 women to encourage such women to accept less than
11 the minimum protections available under this sec-
12 tion;

13 (3) penalize or otherwise reduce or limit the re-
14 imbursement of an attending provider because such
15 provider provided care to an individual participant
16 or beneficiary in accordance with this section;

17 (4) provide incentives (monetary or otherwise)
18 to an attending provider to induce such provider to
19 provide care to an individual participant or bene-
20 ficiary in a manner inconsistent with this section; or

21 (5) subject to subsection (c)(3), restrict benefits
22 for any portion of a period within a hospital length
23 of stay required under subsection (a) in a manner
24 which is less favorable than the benefits provided for
25 any preceding portion of such stay.

1 (c) RULES OF CONSTRUCTION.—

2 (1) Nothing in this section shall be construed to
3 require a woman who is a participant or
4 beneficiary—

5 (A) to undergo a mastectomy or lymph
6 node dissection in a hospital; or

7 (B) to stay in the hospital for a fixed pe-
8 riod of time following a mastectomy or lymph
9 node dissection.

10 (2) This section shall not apply with respect to
11 any group health plan, or any group health insur-
12 ance coverage offered by a health insurance issuer,
13 which does not provide benefits for hospital lengths
14 of stay in connection with a mastectomy or lymph
15 node dissection for the treatment of breast cancer.

16 (3) Nothing in this section shall be construed as
17 preventing a group health plan or issuer from impos-
18 ing deductibles, coinsurance, or other cost-sharing in
19 relation to benefits for hospital lengths of stay in
20 connection with a mastectomy or lymph node dissec-
21 tion for the treatment of breast cancer under the
22 plan (or under health insurance coverage offered in
23 connection with a group health plan), except that
24 such coinsurance or other cost-sharing for any por-
25 tion of a period within a hospital length of stay re-

1 required under subsection (a) may not be greater than
2 such coinsurance or cost-sharing for any preceding
3 portion of such stay.

4 (d) LEVEL AND TYPE OF REIMBURSEMENTS.—Noth-
5 ing in this section shall be construed to prevent a group
6 health plan or a health insurance issuer offering group
7 health insurance coverage from negotiating the level and
8 type of reimbursement with a provider for care provided
9 in accordance with this section.

10 (e) EXCEPTION FOR HEALTH INSURANCE COVERAGE
11 IN CERTAIN STATES.—

12 (1) IN GENERAL.—The requirements of this
13 section shall not apply with respect to health insur-
14 ance coverage if there is a State law (as defined in
15 section 2723(d)(1) of the Public Health Service Act)
16 for a State that regulates such coverage that is de-
17 scribed in any of the following subparagraphs:

18 (A) Such State law requires such coverage
19 to provide for at least a 48-hour hospital length
20 of stay following a mastectomy performed for
21 treatment of breast cancer and at least a 24-
22 hour hospital length of stay following a lymph
23 node dissection for treatment of breast cancer.

24 (B) Such State law requires, in connection
25 with such coverage for surgical treatment of

1 breast cancer, that the hospital length of stay
 2 for such care is left to the decision of (or re-
 3 quired to be made by) the attending provider in
 4 consultation with the woman involved.

5 (2) CONSTRUCTION.—Section 2723(a)(1) of the
 6 Public Health Service Act and section 731(a)(1) of
 7 the Employee Retirement Income Security Act of
 8 1974 shall not be construed as superseding a State
 9 law described in paragraph (1).

10 CHAPTER 7—DEFINITIONS

11 SEC. ___ 191. DEFINITIONS.

12 (a) INCORPORATION OF GENERAL DEFINITIONS.—
 13 The provisions of section 2971 of the Public Health Serv-
 14 ice Act shall apply for purposes of this subtitle in the same
 15 manner as they apply for purposes of title XXVII of such
 16 Act.

17 (b) SECRETARY.—Except as otherwise provided, the
 18 term “Secretary” means the Secretary of Health and
 19 Human Services, in consultation with the Secretary of
 20 Labor and the Secretary of the Treasury and the term
 21 “appropriate Secretary” means the Secretary of Health
 22 and Human Services in relation to carrying out this sub-
 23 title under sections 2707 and 2753 of the Public Health
 24 Service Act, the Secretary of Labor in relation to carrying
 25 out this subtitle under section 714 of the Employee Retire-

1 ment Income Security Act of 1974, and the Secretary of
2 the Treasury in relation to carrying out this subtitle under
3 chapter 100 and section 4980D of the Internal Revenue
4 Code of 1986.

5 (c) ADDITIONAL DEFINITIONS.—For purposes of this
6 subtitle:

7 (1) APPLICABLE AUTHORITY.—The term “ap-
8 plicable authority” means—

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

12 (B) in the case of a health insurance issuer
13 with respect to a specific provision of this sub-
14 title, the applicable State authority (as defined
15 in section 2791(d) of the Public Health Service
16 Act), or the Secretary of Health and Human
17 Services, if such Secretary is enforcing such
18 provision under section 2722(a)(2) or
19 2761(a)(2) of the Public Health Service Act.

20 (2) CLINICAL PEER.—The term “clinical peer”
21 means, with respect to a review or appeal, a physi-
22 cian (allopathic or osteopathic) or other health care
23 professional who holds a non-restricted license in a
24 State and who is appropriately credentialed in the
25 same or similar specialty as typically manages the

1 medical condition, procedure, or treatment under re-
2 view or appeal and includes a pediatric specialist
3 where appropriate; except that only a physician may
4 be a clinical peer with respect to the review or ap-
5 peal of treatment rendered by a physician.

6 (3) HEALTH CARE PROVIDER.—The term
7 “health care provider” includes a physician or other
8 health care professional, as well as an institutional
9 provider of health care services.

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

17 (5) PARTICIPATING.—The term “participating”
18 means, with respect to a health care provider that
19 provides health care items and services to a partici-
20 pant, beneficiary, or enrollee under group health
21 plan or health insurance coverage offered by a
22 health insurance issuer, a health care provider that
23 furnishes such items and services under a contract
24 or other arrangement with the plan or issuer.

1 **SEC. ____192. PREEMPTION; STATE FLEXIBILITY; CON-**
2 **STRUCTION.**

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

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

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

20 (b) RULES OF CONSTRUCTION.—Except as provided
21 in section ____152, nothing in this subtitle shall be con-
22 strued as requiring a group health plan or health insur-
23 ance coverage to provide specific benefits under the terms
24 of such plan or coverage.

25 (c) DEFINITIONS.—For purposes of this section:

1 (1) STATE LAW.—The term “State law” in-
2 cludes all laws, decisions, rules, regulations, or other
3 State action having the effect of law, of any State.
4 A law of the United States applicable only to the
5 District of Columbia shall be treated as a State law
6 rather than a law of the United States.

7 (2) STATE.—The term “State” includes a
8 State, the Northern Mariana Islands, any political
9 subdivisions of a State or such Islands, or any agen-
10 cy or instrumentality of either.

11 **SEC. ___193. REGULATIONS.**

12 The Secretaries of Health and Human Services,
13 Labor, and the Treasury shall issue such regulations as
14 may be necessary or appropriate to carry out this subtitle.
15 Such regulations shall be issued consistent with section
16 104 of the Health Insurance Portability and Account-
17 ability Act of 1996. Such Secretaries may promulgate any
18 interim final rules as the Secretaries determine are appro-
19 priate to carry out this subtitle.

1 **Subtitle B—Application of Patient**
2 **Protection Standards to Group**
3 **Health Plans and Health Insur-**
4 **ance Coverage Under Public**
5 **Health Service Act**

6 **SEC. ____201. APPLICATION TO GROUP HEALTH PLANS AND**
7 **GROUP HEALTH INSURANCE COVERAGE.**

8 (a) IN GENERAL.—Subpart 2 of part A of title
9 XXVII of the Public Health Service Act, as amended by
10 the Omnibus Consolidated and Emergency Supplemental
11 Appropriations Act, 1999 (Public Law 105–277), is
12 amended by adding at the end the following new section:

13 **“SEC. 2707. PATIENT PROTECTION STANDARDS.**

14 “(a) IN GENERAL.—Each group health plan shall
15 comply with patient protection requirements under sub-
16 title A of the Patients’ Bill of Rights Act of 1999, and
17 each health insurance issuer shall comply with patient pro-
18 tection requirements under such subtitle with respect to
19 group health insurance coverage it offers, and such re-
20 quirements shall be deemed to be incorporated into this
21 subsection.

22 “(b) NOTICE.—A group health plan shall comply with
23 the notice requirement under section 711(d) of the Em-
24 ployee Retirement Income Security Act of 1974 with re-
25 spect to the requirements referred to in subsection (a) and

1 a health insurance issuer shall comply with such notice
2 requirement as if such section applied to such issuer and
3 such issuer were a group health plan.”.

4 (b) CONFORMING AMENDMENT.—Section
5 2721(b)(2)(A) of the Public Health Service Act (42
6 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting
7 “(other than section 2707)” after “requirements of such
8 subparts”.

9 **SEC. ___ 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
10 **ANCE COVERAGE.**

11 Subpart 3 of part B of title XXVII of the Public
12 Health Service Act, as amended by the Omnibus Consoli-
13 dated and Emergency Supplemental Appropriations Act,
14 1999 (Public Law 105–277), is amended by adding at the
15 end the following new section:

16 **“SEC. 2753. PATIENT PROTECTION STANDARDS.**

17 “(a) IN GENERAL.—Each health insurance issuer
18 shall comply with patient protection requirements under
19 subtitle A of the Patients’ Bill of Rights Act of 1999 with
20 respect to individual health insurance coverage it offers,
21 and such requirements shall be deemed to be incorporated
22 into this subsection.

23 “(b) NOTICE.—A health insurance issuer under this
24 part shall comply with the notice requirement under sec-
25 tion 711(d) of the Employee Retirement Income Security

1 Act of 1974 with respect to the requirements of such sub-
 2 title as if such section applied to such issuer and such
 3 issuer were a group health plan.”.

4 **Subtitle C—Amendments to the**
 5 **Employee Retirement Income**
 6 **Security Act of 1974**

7 **SEC. ___301. APPLICATION OF PATIENT PROTECTION**
 8 **STANDARDS TO GROUP HEALTH PLANS AND**
 9 **GROUP HEALTH INSURANCE COVERAGE**
 10 **UNDER THE EMPLOYEE RETIREMENT IN-**
 11 **COME SECURITY ACT OF 1974.**

12 (a) IN GENERAL.—Subpart B of part 7 of subtitle
 13 B of title I of the Employee Retirement Income Security
 14 Act of 1974, as amended by the Omnibus Consolidated
 15 and Emergency Supplemental Appropriations Act, 1999
 16 (Public Law 105–277), is amended by adding at the end
 17 the following:

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

19 “(a) IN GENERAL.—Subject to subsection (b), a
 20 group health plan (and a health insurance issuer offering
 21 group health insurance coverage in connection with such
 22 a plan) shall comply with the requirements of subtitle A
 23 of the Patients’ Bill of Rights Act of 1999 (as in effect
 24 as of the date of the enactment of such Act), and such

1 requirements shall be deemed to be incorporated into this
2 subsection.

3 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-
4 MENTS.—

5 “(1) SATISFACTION OF CERTAIN REQUIRE-
6 MENTS THROUGH INSURANCE.—For purposes of
7 subsection (a), insofar as a group health plan pro-
8 vides benefits in the form of health insurance cov-
9 erage through a health insurance issuer, the plan
10 shall be treated as meeting the following require-
11 ments of subtitle A of the Patients’ Bill of Rights
12 Act of 1999 with respect to such benefits and not
13 be considered as failing to meet such requirements
14 because of a failure of the issuer to meet such re-
15 quirements so long as the plan sponsor or its rep-
16 resentatives did not cause such failure by the issuer:

17 “(A) Section ____101 (relating to access
18 to emergency care).

19 “(B) Section ____102(a)(1) (relating to of-
20 fering option to purchase point-of-service cov-
21 erage), but only insofar as the plan is meeting
22 such requirement through an agreement with
23 the issuer to offer the option to purchase point-
24 of-service coverage under such section.

1 “(C) Section ____103 (relating to choice of
2 providers).

3 “(D) Section ____104 (relating to access
4 to specialty care).

5 “(E) Section ____105(a)(1) (relating to
6 continuity in case of termination of provider
7 contract) and section ____105(a)(2) (relating
8 to continuity in case of termination of issuer
9 contract), but only insofar as a replacement
10 issuer assumes the obligation for continuity of
11 care.

12 “(F) Section ____106 (relating to coverage
13 for individuals participating in approved clinical
14 trials.)

15 “(G) Section ____107 (relating to access
16 to needed prescription drugs).

17 “(H) Section ____108 (relating to ade-
18 quacy of provider network).

19 “(I) Chapter 2 of subtitle A (relating to
20 quality assurance).

21 “(J) Section ____143 (relating to addi-
22 tional rules regarding participation of health
23 care professionals).

1 “(K) Section ____152 (relating to stand-
2 ards relating to benefits for certain breast can-
3 cer treatment).

4 “(2) INFORMATION.—With respect to informa-
5 tion required to be provided or made available under
6 section ____121, in the case of a group health plan
7 that provides benefits in the form of health insur-
8 ance coverage through a health insurance issuer, the
9 Secretary shall determine the circumstances under
10 which the plan is not required to provide or make
11 available the information (and is not liable for the
12 issuer’s failure to provide or make available the in-
13 formation), if the issuer is obligated to provide and
14 make available (or provides and makes available)
15 such information.

16 “(3) GRIEVANCE AND INTERNAL APPEALS.—
17 With respect to the grievance system and internal
18 appeals process required to be established under sec-
19 tions 131 and 132, in the case of a group health
20 plan that provides benefits in the form of health in-
21 surance coverage through a health insurance issuer,
22 the Secretary shall determine the circumstances
23 under which the plan is not required to provide for
24 such system and process (and is not liable for the
25 issuer’s failure to provide for such system and proc-

1 ess), if the issuer is obligated to provide for (and
2 provides for) such system and process.

3 “(4) EXTERNAL APPEALS.—Pursuant to rules
4 of the Secretary, insofar as a group health plan en-
5 ters into a contract with a qualified external appeal
6 entity for the conduct of external appeal activities in
7 accordance with section ____133, the plan shall be
8 treated as meeting the requirement of such section
9 and is not liable for the entity’s failure to meet any
10 requirements under such section.

11 “(5) APPLICATION TO PROHIBITIONS.—Pursu-
12 ant to rules of the Secretary, if a health insurance
13 issuer offers health insurance coverage in connection
14 with a group health plan and takes an action in vio-
15 lation of any of the following sections, the group
16 health plan shall not be liable for such violation un-
17 less the plan caused such violation:

18 “(A) Section ____109 (relating to non-
19 discrimination in delivery of services).

20 “(B) Section ____141 (relating to prohibi-
21 tion of interference with certain medical com-
22 munications).

23 “(C) Section ____142 (relating to prohibi-
24 tion against transfer of indemnification or im-
25 proper incentive arrangements).

1 “(D) Section ____144 (relating to prohibi-
2 tion on retaliation).

3 “(E) Section ____151 (relating to pro-
4 moting good medical practice).

5 “(6) CONSTRUCTION.—Nothing in this sub-
6 section shall be construed to affect or modify the re-
7 sponsibilities of the fiduciaries of a group health
8 plan under part 4 of subtitle B.

9 “(7) APPLICATION TO CERTAIN PROHIBITIONS
10 AGAINST RETALIATION.—With respect to compliance
11 with the requirements of section ____144(b)(1) of
12 the Patients’ Bill of Rights Act of 1999, for pur-
13 poses of this subtitle the term ‘group health plan’ is
14 deemed to include a reference to an institutional
15 health care provider.

16 “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

17 “(1) COMPLAINTS.—Any protected health care
18 professional who believes that the professional has
19 been retaliated or discriminated against in violation
20 of section ____144(b)(1) of the Patients’ Bill of
21 Rights Act of 1999 may file with the Secretary a
22 complaint within 180 days of the date of the alleged
23 retaliation or discrimination.

24 “(2) INVESTIGATION.—The Secretary shall in-
25 vestigate such complaints and shall determine if a

1 violation of such section has occurred and, if so,
2 shall issue an order to ensure that the protected
3 health care professional does not suffer any loss of
4 position, pay, or benefits in relation to the plan,
5 issuer, or provider involved, as a result of the viola-
6 tion found by the Secretary.

7 “(d) CONFORMING REGULATIONS.—The Secretary
8 may issue regulations to coordinate the requirements on
9 group health plans under this section with the require-
10 ments imposed under the other provisions of this title.”.

11 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
12 REQUIREMENT.—Section 503 of the Employee Retirement
13 Income Security Act of 1974 (29 U.S.C. 1133) is amended
14 by inserting “(a)” after “SEC. 503.” and by adding at
15 the end the following new subsection:

16 “(b) In the case of a group health plan (as defined
17 in section 733) compliance with the requirements of chap-
18 ter 4 (and section ____115) of subtitle A of the Patients’
19 Bill of Rights Act of 1999 in the case of a claims denial
20 shall be deemed compliance with subsection (a) with re-
21 spect to such claims denial.”.

22 (c) CONFORMING AMENDMENTS.—

23 (1) Section 732(a) of the Employee Retirement
24 Income Security Act of 1974 (29 U.S.C. 1185(a)) is

1 amended by striking “section 711” and inserting
2 “sections 711 and 714”.

3 (2) The table of contents in section 1 of the
4 Employee Retirement Income Security Act of 1974,
5 as amended by the Omnibus Consolidated and
6 Emergency Supplemental Appropriations Act, 1999
7 (Public Law 105–277), is amended by inserting
8 after the item relating to section 713 the following
9 new item:

“Sec. 714. Patient protection standards.”.

10 (3) Section 502(b)(3) of the Employee Retirement
11 Income Security Act of 1974 (29 U.S.C.
12 1132(b)(3)) is amended by inserting “(other than
13 section 144(b))” after “part 7”.

14 **SEC. ___ 302. ERISA PREEMPTION NOT TO APPLY TO CER-**
15 **TAIN ACTIONS INVOLVING HEALTH INSUR-**
16 **ANCE POLICYHOLDERS.**

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

20 “(e) PREEMPTION NOT TO APPLY TO CERTAIN AC-
21 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-
22 FITS.—

23 “(1) IN GENERAL.—Except as provided in this
24 subsection, nothing in this title shall be construed to
25 invalidate, impair, or supersede any cause of action

1 brought by a plan participant or beneficiary (or the
2 estate of a plan participant or beneficiary) under
3 State law to recover damages resulting from per-
4 sonal injury or for wrongful death against any
5 person—

6 “(A) in connection with the provision of in-
7 surance, administrative services, or medical
8 services by such person to or for a group health
9 plan (as defined in section 733), or

10 “(B) that arises out of the arrangement by
11 such person for the provision of such insurance,
12 administrative services, or medical services by
13 other persons.

14 “(2) EXCEPTION FOR EMPLOYERS AND OTHER
15 PLAN SPONSORS.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (B), paragraph (1) does not authorize—

18 “(i) any cause of action against an
19 employer or other plan sponsor maintain-
20 ing the group health plan or against an
21 employee of such an employer or sponsor
22 acting within the scope of employment, or

23 “(ii) a right of recovery or indemnity
24 by a person against an employer or other
25 plan sponsor (or such an employee) for

1 damages assessed against the person pur-
2 suant to a cause of action under paragraph
3 (1).

4 “(B) SPECIAL RULE.—Subparagraph (A)
5 shall not preclude any cause of action described
6 in paragraph (1) against an employer or other
7 plan sponsor (or against an employee of such
8 an employer or sponsor acting within the scope
9 of employment) if—

10 “(i) such action is based on the em-
11 ployer’s or other plan sponsor’s (or em-
12 ployee’s) exercise of discretionary authority
13 to make a decision on a claim for benefits
14 covered under the plan or health insurance
15 coverage in the case at issue; and

16 “(ii) the exercise by such employer or
17 other plan sponsor (or employee of such
18 authority) resulted in personal injury or
19 wrongful death.

20 “(3) CONSTRUCTION.—Nothing in this sub-
21 section shall be construed as permitting a cause of
22 action under State law for the failure to provide an
23 item or service which is not covered under the group
24 health plan involved.

1 “(4) **PERSONAL INJURY DEFINED.**—For pur-
 2 poses of this subsection, the term ‘personal injury’
 3 means a physical injury and includes an injury aris-
 4 ing out of the treatment (or failure to treat) a men-
 5 tal illness or disease.”.

6 (b) **EFFECTIVE DATE.**—The amendment made by
 7 subsection (a) shall apply to acts and omissions occurring
 8 on or after the date of the enactment of this Act from
 9 which a cause of action arises.

10 **SEC. ____303. LIMITATION IN ACTIONS.**

11 Section 502 of Employee Retirement Income Security
 12 Act of 1974 (29 U.S.C. 1132) is amended by adding at
 13 the end the following:

14 “(n)(1) Except as provided in this section, no action
 15 may be brought under subsection (a)(1)(B), (a)(2), or
 16 (a)(3) by a participant or beneficiary seeking relief based
 17 on the application of any provision in chapter 1 (other
 18 than section ____109) of subtitle A, chapter 5 of subtitle
 19 A, or section ____115 or ____151 of the Patient’s Bill
 20 of Rights Act of 1999 (as incorporated under section 714).

21 “(2) An action may be brought under subsection
 22 (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary
 23 seeking relief based on the application of section ____101,
 24 ____104, ____105, ____106, ____107(a)(3), ____107(b),
 25 ____115, or ____151 of the Patient’s Bill of Rights Act

1 of 1999 (as incorporated under section 714) to the indi-
 2 vidual circumstances of that participant or beneficiary; ex-
 3 cept that—

4 “(A) such an action may not be brought or
 5 maintained as a class action; and

6 “(B) in such an action relief may only provide
 7 for the provision of (or payment for) benefits, items,
 8 or services denied to the individual participant or
 9 beneficiary involved (and for attorney’s fees and the
 10 costs of the action, at the discretion of the court)
 11 and shall not provide for any other relief to the par-
 12 ticipant or beneficiary and for any relief to any other
 13 person.

14 “(3) Nothing in this subsection shall be construed as
 15 affecting any action brought by the Secretary.”.

16 **Subtitle D—Application to Group**
 17 **Health Plans under the Internal**
 18 **Revenue Code of 1986**

19 **SEC. ___401. AMENDMENTS TO THE INTERNAL REVENUE**
 20 **CODE OF 1986.**

21 Subchapter B of chapter 100 of the Internal Revenue
 22 Code of 1986 (as amended by section 1531(a) of the Tax-
 23 payer Relief Act of 1997) is amended—

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

“Sec. 9813. Standard relating to patient freedom of choice.”;
 and

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

6 **“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF**
 7 **RIGHTS.**

8 “A group health plan shall comply with the require-
 9 ments of subtitle A of the Patients’ Bill of Rights Act of
 10 1999 (as in effect as of the date of the enactment of such
 11 Act), and such requirements shall be deemed to be incor-
 12 porated into this section.”.

13 **Subtitle E—Effective Dates;**
 14 **Coordination in Implementation**

15 **SEC. ___ 501. EFFECTIVE DATES AND RELATED RULES.**

16 (a) GROUP HEALTH COVERAGE.—

17 (1) IN GENERAL.—Subject to paragraph (2),
 18 the amendments made by sections 201(a), 301, and
 19 401 (and subtitle A insofar as it relates to such sec-
 20 tions) shall apply with respect to group health plans,
 21 and health insurance coverage offered in connection
 22 with group health plans, for plan years beginning on
 23 or after October 1, 2000 (in this section referred to
 24 as the “general effective date”).

1 (2) TREATMENT OF COLLECTIVE BARGAINING
2 AGREEMENTS.—In the case of a group health plan
3 maintained pursuant to 1 or more collective bar-
4 gaining agreements between employee representa-
5 tives and 1 or more employers ratified before the
6 date of enactment of this title, the amendments
7 made by sections ____201(a), ____301, and
8 ____401 (and subtitle A insofar as it relates to such
9 sections) shall not apply to plan years beginning be-
10 fore the later of—

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

16 (B) the general effective date.

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

23 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—
24 The amendments made by section ____202 shall apply
25 with respect to individual health insurance coverage of-

1 fered, sold, issued, renewed, in effect, or operated in the
2 individual market on or after the general effective date.

3 (c) TREATMENT OF RELIGIOUS NONMEDICAL PRO-
4 VIDERS.—

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

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

11 (B) require such plans or issuers to—

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

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

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

22 (iv) compel a participant or bene-
23 ficiary to undergo a medical examination
24 or test as a condition of receiving health

1 insurance coverage for treatment by a reli-
2 gious nonmedical provider; or

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

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

15 **SEC. ___ 502. COORDINATION IN IMPLEMENTATION.**

16 Section 104(1) of Health Insurance Portability and
17 Accountability Act of 1996 is amended by striking “this
18 subtitle (and the amendments made by this subtitle and
19 section 401)” and inserting “the provisions of part 7 of
20 subtitle B of title I of the Employee Retirement Income
21 Security Act of 1974, the provisions of parts A and C of
22 title XXVII of the Public Health Service Act, chapter 100
23 of the Internal Revenue Code of 1986, and subtitle A of
24 the Patients’ Bill of Rights Act of 1999”.

1 **SEC. ___503. NO IMPACT ON SOCIAL SECURITY TRUST**
2 **FUND.**

3 (a) **IN GENERAL.**—Nothing in this title shall be con-
4 strued to alter or amend the Social Security Act (or any
5 regulation promulgated under that Act).

6 (b) **TRANSFERS.**—

7 (1) **ESTIMATE OF SECRETARY.**—The Secretary
8 of the Treasury shall annually estimate the impact
9 that the enactment of this title has on the income
10 and balances of the trust funds established under
11 section 201 of the Social Security Act (42 U.S.C.
12 401).

13 (2) **TRANSFER OF FUNDS.**—If, under para-
14 graph (1), the Secretary of the Treasury estimates
15 that the enactment of this title has a negative im-
16 pact on the income and balances of the trust funds
17 established under section 201 of the Social Security
18 Act (42 U.S.C. 401), the Secretary shall transfer,
19 not less frequently than quarterly, from the general
20 revenues of the Federal Government an amount suf-
21 ficient so as to ensure that the income and balances
22 of such trust funds are not reduced as a result of
23 the enactment of such title.

1 **Subtitle F—Revenue-Related**
2 **Provisions**

3 **SEC. ____601. INFORMATION REQUIREMENTS.**

4 (a) INFORMATION FROM GROUP HEALTH PLANS.—

5 Section 1862(b) of the Social Security Act (42 U.S.C.
6 1395y(b)) is amended by adding at the end the following:

7 “(7) INFORMATION FROM GROUP HEALTH
8 PLANS.—

9 “(A) PROVISION OF INFORMATION BY
10 GROUP HEALTH PLANS.—The administrator of
11 a group health plan subject to the requirements
12 of paragraph (1) shall provide to the Secretary
13 such of the information elements described in
14 subparagraph (C) as the Secretary specifies,
15 and in such manner and at such times as the
16 Secretary may specify (but not more frequently
17 than 4 times per year), with respect to each in-
18 dividual covered under the plan who is entitled
19 to any benefits under this title.

20 “(B) PROVISION OF INFORMATION BY EM-
21 PLOYERS AND EMPLOYEE ORGANIZATIONS.—An
22 employer (or employee organization) that main-
23 tains or participates in a group health plan sub-
24 ject to the requirements of paragraph (1) shall
25 provide to the administrator of the plan such of

1 the information elements required to be pro-
2 vided under subparagraph (A), and in such
3 manner and at such times as the Secretary may
4 specify, at a frequency consistent with that re-
5 quired under subparagraph (A) with respect to
6 each individual described in subparagraph (A)
7 who is covered under the plan by reason of em-
8 ployment with that employer or membership in
9 the organization.

10 “(C) INFORMATION ELEMENTS.—The in-
11 formation elements described in this subpara-
12 graph are the following:

13 “(i) ELEMENTS CONCERNING THE IN-
14 DIVIDUAL.—

15 “(I) The individual’s name.

16 “(II) The individual’s date of
17 birth.

18 “(III) The individual’s sex.

19 “(IV) The individual’s social se-
20 curity insurance number.

21 “(V) The number assigned by the
22 Secretary to the individual for claims
23 under this title.

24 “(VI) The family relationship of
25 the individual to the person who has

1 or had current or employment status
2 with the employer.

3 “(ii) ELEMENTS CONCERNING THE
4 FAMILY MEMBER WITH CURRENT OR
5 FORMER EMPLOYMENT STATUS.—

6 “(I) The name of the person in
7 the individual’s family who has cur-
8 rent or former employment status
9 with the employer.

10 “(II) That person’s social secu-
11 rity insurance number.

12 “(III) The number or other iden-
13 tifier assigned by the plan to that per-
14 son.

15 “(IV) The periods of coverage for
16 that person under the plan.

17 “(V) The employment status of
18 that person (current or former) dur-
19 ing those periods of coverage.

20 “(VI) The classes (of that per-
21 son’s family members) covered under
22 the plan.

23 “(iii) PLAN ELEMENTS.—

24 “(I) The items and services cov-
25 ered under the plan.

1 “(II) The name and address to
2 which claims under the plan are to be
3 sent.

4 “(iv) ELEMENTS CONCERNING THE
5 EMPLOYER.—

6 “(I) The employer’s name.

7 “(II) The employer’s address.

8 “(III) The employer identifica-
9 tion number of the employer.

10 “(D) USE OF IDENTIFIERS.—The adminis-
11 trator of a group health plan shall utilize a
12 unique identifier for the plan in providing infor-
13 mation under subparagraph (A) and in other
14 transactions, as may be specified by the Sec-
15 retary, related to the provisions of this sub-
16 section. The Secretary may provide to the ad-
17 ministrator the unique identifier described in
18 the preceding sentence.

19 “(E) PENALTY FOR NONCOMPLIANCE.—
20 Any entity that knowingly and willfully fails to
21 comply with a requirement imposed by the pre-
22 vious subparagraphs shall be subject to a civil
23 money penalty not to exceed \$1,000 for each in-
24 cident of such failure. The provisions of section
25 1128A (other than subsections (a) and (b))

1 shall apply to a civil money penalty under the
 2 previous sentence in the same manner as those
 3 provisions apply to a penalty or proceeding
 4 under section 1128A(a).”

5 (b) EFFECTIVE DATE.—The amendment made by
 6 subsection (a) shall take effect 180 days after the date
 7 of the enactment of this Act.

8 **SEC. ____602. EXTENSION OF HAZARDOUS SUBSTANCE**
 9 **SUPERFUND TAXES.**

10 (a) EXTENSION OF TAXES.—

11 (1) ENVIRONMENTAL TAX.—Section 59A(e) of
 12 the Internal Revenue Code of 1986 is amended to
 13 read as follows:

14 “(e) APPLICATION OF TAX.—The tax imposed by this
 15 section shall apply to taxable years beginning after De-
 16 cember 31, 1986, and before January 1, 1996, and to tax-
 17 able years beginning after December 31, 1998, and before
 18 January 1, 2010.”

19 (2) EXCISE TAXES.—Section 4611(e) of such
 20 Code is amended to read as follows:

21 “(e) APPLICATION OF HAZARDOUS SUBSTANCE
 22 SUPERFUND FINANCING RATE.—The Hazardous Sub-
 23 stance Superfund financing rate under this section shall
 24 apply after December 31, 1986, and before January 1,

1 1996, and after September 15, 1999, and before October
2 1, 2009.”

3 (b) EFFECTIVE DATES.—

4 (1) INCOME TAX.—The amendment made by
5 subsection (a)(1) shall apply to taxable years begin-
6 ning after December 31, 1998.

7 (2) EXCISE TAX.—The amendment made by
8 subsection (a)(2) shall take effect on September 15,
9 1999.

10 **SEC. ___603. MODIFICATION TO FOREIGN TAX CREDIT**
11 **CARRYBACK AND CARRYOVER PERIODS.**

12 (a) IN GENERAL.—Section 904(c) of the Internal
13 Revenue Code of 1986 (relating to limitation on credit)
14 is amended—

15 (1) by striking “in the second preceding taxable
16 year,” and

17 (2) by striking “or fifth” and inserting “fifth,
18 sixth, or seventh”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall apply to credits arising in taxable
21 years beginning after December 31, 2001.

22 **SEC. ___604. LIMITATIONS ON WELFARE BENEFIT FUNDS**
23 **OF 10 OR MORE EMPLOYER PLANS.**

24 (a) BENEFITS TO WHICH EXCEPTION APPLIES.—
25 Section 419A(f)(6)(A) of the Internal Revenue Code of

1 1986 (relating to exception for 10 or more employer plans)
2 is amended to read as follows:

3 “(A) IN GENERAL.—This subpart shall not
4 apply to a welfare benefit fund which is part of
5 a 10 or more employer plan if the only benefits
6 provided through the fund are 1 or more of the
7 following:

8 “(i) Medical benefits.

9 “(ii) Disability benefits.

10 “(iii) Group term life insurance bene-
11 fits which do not provide for any cash sur-
12 render value or other money that can be
13 paid, assigned, borrowed, or pledged for
14 collateral for a loan.

15 The preceding sentence shall not apply to any
16 plan which maintains experience-rating arrange-
17 ments with respect to individual employers.”

18 (b) LIMITATION ON USE OF AMOUNTS FOR OTHER
19 PURPOSES.—Section 4976(b) of the Internal Revenue
20 Code of 1986 (defining disqualified benefit) is amended
21 by adding at the end the following new paragraph:

22 “(5) SPECIAL RULE FOR 10 OR MORE EM-
23 PLOYER PLANS EXEMPTED FROM PREFUNDING LIM-
24 ITS.—For purposes of paragraph (1)(C), if—

1 “(A) subpart D of part I of subchapter D
2 of chapter 1 does not apply by reason of section
3 419A(f)(6) to contributions to provide 1 or
4 more welfare benefits through a welfare benefit
5 fund under a 10 or more employer plan, and

6 “(B) any portion of the welfare benefit
7 fund attributable to such contributions is used
8 for a purpose other than that for which the con-
9 tributions were made,

10 then such portion shall be treated as reverting to the
11 benefit of the employers maintaining the fund.”

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to contributions paid or accrued
14 after the date of the enactment of this Act, in taxable
15 years ending after such date.

16 **SEC. ___ 605. MODIFICATION OF INSTALLMENT METHOD**
17 **AND REPEAL OF INSTALLMENT METHOD FOR**
18 **ACCRUAL METHOD TAXPAYERS.**

19 (a) REPEAL OF INSTALLMENT METHOD FOR AC-
20 CRUAL BASIS TAXPAYERS.—

21 (1) IN GENERAL.—Subsection (a) of section
22 453 of the Internal Revenue Code of 1986 (relating
23 to installment method) is amended to read as fol-
24 lows:

25 “(a) USE OF INSTALLMENT METHOD.—

1 “(1) IN GENERAL.—Except as otherwise pro-
2 vided in this section, income from an installment
3 sale shall be taken into account for purposes of this
4 title under the installment method.

5 “(2) ACCRUAL METHOD TAXPAYER.—The in-
6 stallment method shall not apply to income from an
7 installment sale if such income would be reported
8 under an accrual method of accounting without re-
9 gard to this section. The preceding sentence shall
10 not apply to a disposition described in subparagraph
11 (A) or (B) of subsection (1)(2).”

12 (2) CONFORMING AMENDMENTS.—Sections
13 453(d)(1), 453(i)(1), and 453(k) of the Internal
14 Revenue Code of 1986 are each amended by striking
15 “(a)” each place it appears and inserting “(a)(1)”.

16 (b) MODIFICATION OF PLEDGE RULES.—Paragraph
17 (4) of section 453A(d) (relating to pledges, etc., of install-
18 ment obligations) is amended by adding at the end the
19 following: “A payment shall be treated as directly secured
20 by an interest in an installment obligation to the extent
21 an arrangement allows the taxpayer to satisfy all or a por-
22 tion of the indebtedness with the installment obligation.”

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to sales or other dispositions occur-
25 ring on or after the date of the enactment of this Act.