Hoekstra
Holden
Holt
Horn
Hostettler
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Istook
Jackson (IL)
Jenkins
John
Johnson (CT)
Johnson, Sam
Jones (NC)
Kanjorski
Kasich
Kelly
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kolbe
Kuykendall
LaHood
Lampson
Lantos
Larson
Latham
LaTourette
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lofgren
Lucas (KY)
Lucas (OK)
Maloney (CT)
Maloney (NY)
Manzullo
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCrery
McHugh
McInnis
McIntosh
McIntyre
McKeon
McKinney
Meehan
Meeks (NY)
Menendez
Metcalf
Mica
Millender-McDonald
Miller (FL)
Miller, Gary
Minge
Mink
Mollohan
Moore
Moran (VA)
Morella
Murtha
Myrick
Nadler
Napolitano
Nethercutt
Ney
Northup
Norwood
Nussle
Obey
Olver
Ortiz
Ose
Oxley
Packard
Pascrell
Pastor
Paul
Payne
Pease
Peterson (PA)
Petri
Phelps
Pickering
Pitts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Rangel
Regula
Reyes
Reynolds
Rivers
Rodriguez
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Royce
Rush
Ryan (WI)
Ryun (KS)
Salmon
Sanchez
Sanders
Sandlin
Sanford
Saxton
Schakowsky
Scott
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauscher
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tierney
Toomey
Towns
Traficant
Turner
Upton
Vitter
Walden
Walsh
Watkins
Watt (NC)
Watts (OK)
Waxman
Weiner
Weldon (FL)
Wexler
Weygand
Whitfield
Wicker
Wilson
Wise
Wolf
Woolsey
Wu
Wynn
Young (FL)

NAYS—73

Aderholt
Allen
Baldacci
Bilbray
Borski
Brady (PA)
Capuano
Chenoweth-Hage
Clay
Clyburn
Costello
Crane
Crowley
DeFazio
Dickey
English
Etheridge
Evans
Filner
Frost
Gibbons
Gutierrez
Gutknecht
Hastings (FL)
Hefley
Hilleary
Hilliard
Hooley
Hulshof
Hutchinson
Jackson-Lee (TX)
Johnson, E. B.
Jones (OH)
Kucinich
LaFalce
Lee
Lewis (GA)
Lipinski
LoBiondo
Lowey
Luther
McDermott
McNulty
Meek (FL)
Miller, George
Moran (KS)
Neal
Oberstar
Pallone
Peterson (MN)
Pickett
Ramstad
Riley
Sabo
Schaffer
Slaughter
Stark
Stenholm
Strickland
Stupak
Tanner
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Wamp
Waters
Weller

NOT VOTING—19

Abercrombie
Barr
Clement
Davis (IL)
Ehrlich
Ford
Jefferson
Kaptur
Largent
Linder
McCollum
McGovern
Moakley
Owens
Pelosi
Sawyer
Scarborough
Weldon (PA)
Young (AK)

□ 1106

Ms. JACKSON-LEE of Texas and Mr. DICKEY changed their vote from ''yea'' to ''nay.''

So the Journal was approved.

The result of the vote was announced as above recorded.

BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

The SPEAKER pro tempore (Mrs. BIGGERT). Pursuant to House Resolution 323 and rule XXVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the further consideration of the bill, H.R. 2723.

□ 1107

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill (H.R. 2723) to amend Title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, with Mr. HASTINGS of Washington in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. When the Committee of the Whole rose on Wednesday, October 6, 1999, all time for general debate had expired.

Pursuant to the rule, the amendments printed in part A of House Report 106–366 are adopted and the bill, as amended, is considered read for amendment under the 5-minute rule.

The text of H.R. 2723, as amended, is as follows:

H.R. 2723

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

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

Subtitle B—Access to Care

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

Subtitle C—Access to Information

Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

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

Subtitle E—Definitions

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

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

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

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

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

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

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

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

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

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

Sec. 601. Health care paperwork simplification.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization

review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—

(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B).

(B) DEADLINE.—

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

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

(I) receives a request for a prior authorization,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than five business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for prior authorization.

(2) ONGOING CARE.—

(A) CONCURRENT REVIEW.—

(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

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

(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 113, respectively.

(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the reasons for the denial (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 102; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

(1) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

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

SEC. 102. INTERNAL APPEALS PROCEDURES.

(a) RIGHT OF REVIEW.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

(A) shall provide adequate notice in writing to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied (within the meaning of section 101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in a manner calculated to be understood by the participant, beneficiary, or enrollee; and

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

individual (with respect to such coverage) of the decision denying the claim.

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

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

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

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

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

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

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

(2) TIME LIMITS FOR INTERNAL REVIEWS.—

(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

(B) DEADLINE.—

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

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

(I) receives a request for internal review,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than five business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for review.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

(A) in which the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function; or

(B) described in section 101(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

(2) PROCESS.—Under such procedures—

(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 72 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

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

SEC. 103. EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term ''externally appealable decision'' means a denial of claim for benefits (as defined in section 101(f)(2))—

(i) that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or

(ii) in which the decision as to whether a benefit is covered involves a medical judgment.

(B) INCLUSION.—Such term also includes a failure to meet an applicable deadline for internal review under section 102.

(C) EXCLUSIONS.—Such term does not include—

(i) specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment; or

(ii) a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 102(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 102, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(4) FILING FEE REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan or issuer may condition the use of an external appeal process upon payment to the plan or issuer of a filing fee that does not exceed $25.

(B) EXCEPTION FOR INDIGENCY.—The plan or issuer may not require payment of the filing fee in the case of an individual participant, beneficiary, or enrollee who certifies (in a form and manner specified in guidelines established by the Secretary of Health and Human Services) that the individual is indigent (as defined in such guidelines).

(C) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits which is the subject of the appeal.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Except as provided in subparagraph (D), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The applicable authority shall implement procedures—

(i) to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner, and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that all costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT QUALIFIED EXTERNAL APPEAL ENTITY FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

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

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

plan's or issuer's decision is in accordance with the medical needs of the patient involved (as determined by the entity) taking into account, as of the time of the entity's determination, the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraph (D). If the entity determines the decision is in accordance with such needs, the entity shall affirm the decision and to the extent that the entity determines the decision is not in accordance with such needs, the entity shall reverse or modify the decision.

(C) CONSIDERATION OF PLAN OR COVERAGE DEFINITIONS.—In making such determination, the external appeal entity shall consider (but not be bound by) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms.

(D) EVIDENCE.—

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

(I) the decision made by the plan or issuer upon internal review under section 102 and any guidelines or standards used by the plan or issuer in reaching such decision;

(II) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed; and

(III) the opinion of the individual's treating physician or health care professional.

(ii) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

(I) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(II) The results of professional consensus conferences conducted or financed in whole or in part by one or more Government agencies.

(III) Practice and treatment guidelines prepared or financed in whole or in part by Government agencies.

(IV) Government-issued coverage and treatment policies.

(V) Community standard of care and generally accepted principles of professional medical practice.

(VI) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

(VII) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine—

(i) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

(ii) whether an externally appealable decision involves an expedited appeal; and

(iii) for purposes of initiating an external review, whether the internal review process has been completed.

(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to the external appeal entity to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity.

(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

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

(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 72 hours after the time) of requesting an external appeal of the decision;

(iii) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek further review by the courts (or other process) of the external appeal determination.

(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity reverses or modifies the denial of a claim for benefits, the plan or issuer shall—

(i) upon the receipt of the determination, authorize benefits in accordance with such determination;

(ii) take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

(iii) submit information to the entity documenting compliance with the entity's determination and this subparagraph.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

(A) The entity meets the independence requirements of paragraph (3).

(B) The entity conducts external appeal activities through a panel of not fewer than three clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1)—

(I) by the Secretary of Labor;

(II) under a process recognized or approved by the Secretary of Labor; or

(III) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph); or

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

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

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

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

(i) the number of cases reviewed;

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

(iii) the length of time in making determinations on those cases;

(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

(v) such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted.

(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—

(i) FOR EXTERNAL REVIEWS UNDER GROUP HEALTH PLANS.—For purposes of subparagraph (A)(i)(III), the Secretary of Labor may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(i)(I).

(ii) FOR EXTERNAL REVIEWS OF HEALTH INSURANCE ISSUERS.—For purposes of subparagraph (A)(ii)(II), the Secretary of Health and Human Services may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(ii)(II).

(3) INDEPENDENCE REQUIREMENTS.—

(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

(i) the peer or entity does not have a familial, financial, or professional relationship with any related party;

(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(iii) except as provided in paragraph (4), the plan and the issuer have no recourse against the peer or entity in connection with the external review; and

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

(B) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

(ii) the health care professional that provided the health care involved in the coverage decision;

(iii) the institution at which the health care involved in the coverage decision is provided;

(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision; or

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

(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—The determination by an external appeal entity under this section is binding on the plan and issuer involved in the determination.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(1) MONETARY PENALTIES.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(A) to cease and desist from the alleged action or failure to act; and

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

(3) ADDITIONAL CIVIL PENALTIES.—

(A) IN GENERAL.—In addition to any penalty imposed under paragraph (1) or (2), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(i) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity in violation of the terms of such a plan, coverage, or this title; or

(ii) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or plans or coverage.

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

(i) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice, or

(ii) $500,000.

(4) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in paragraph (3)(A) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

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

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

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

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

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

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

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

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer or arrange to be offered to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

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

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

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

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

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

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)), and

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

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with the guidelines established under section 1852(d)(2) of the Social Security Act), if the services are maintenance care or post-stabilization care covered under such guidelines.

SEC. 114. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of gynecological care (including preventive women's health examinations) and pregnancy-related services provided by a participating health care professional, including a physician, who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(2) shall treat the ordering of other obstetrical or gynecological care by such a participating professional as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider.

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

SEC. 117. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition

(as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) DEFINITIONS.—For purposes of this section:

(A) ONGOING SPECIAL CONDITION.—The term ''ongoing special condition'' has the meaning given such term in section 114(b)(3), and also includes pregnancy.

(B) TERMINATION.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

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

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

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

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

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

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

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

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

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

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

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

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

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

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

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

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

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

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

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

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

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

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

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

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

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

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

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

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

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

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

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

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

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

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

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

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

(B) Out-of-network coverage (if any) provided by the plan or coverage.

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

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

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

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 112(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals.

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

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

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

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

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

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

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) NOTICE OF REQUIREMENTS.—Notice of the requirements of this title.

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 101, including under any drug formulary program under section 118.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—A general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which a specified prospective or treating health care professional is (or would be) compensated in connection with the provision of health care under the plan or coverage.

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

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

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

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

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

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

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section

1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

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

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

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

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

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

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

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

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

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

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

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

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

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

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

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

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

(2) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

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

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

(3) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, an actively practicing physician (allopathic or osteopathic) or other actively practicing health care professional who holds a nonrestricted license, and who is appropriately credentialed in the same or similar specialty or subspecialty (as appropriate) as typically handles the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician (allopathic or osteopathic) may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

(4) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974 and in section 2791(a)(1) of the Public Health Service Act.

(6) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(8) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

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

(10) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(11) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

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

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

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

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to provide items and services (including abortions) that are specifically excluded under the plan or coverage.

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

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

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

(A) reimburses hospitals, health professionals, and other providers on the basis of a rate determined by the plan or issuer on a fee-for-service basis without placing the provider at financial risk;

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

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing coverage for any services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

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

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

''SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 112 (relating to choice of providers).

''(B) Section 113 (relating to access to emergency care).

''(C) Section 114 (relating to access to specialty care).

''(D) Section 115 (relating to access to obstetrical and gynecological care).

''(E) Section 116 (relating to access to pediatric care).

''(F) Section 117(a)(1) (relating to continuity in case of termination of provider contract) and section 117(a)(2) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(G) Section 118 (relating to access to needed prescription drugs).

''(H) Section 119 (relating to coverage for individuals participating in approved clinical trials.)

''(I) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the internal appeals process and the grievance system required to be established under sections 102 and 104, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 103, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

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

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.

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

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan as defined in section 733), or

''(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

''(B) LIMITATION ON PUNITIVE DAMAGES.—

''(i) IN GENERAL.—No person shall be liable for any punitive, exemplary, or similar damages in the case of a cause of action brought under subparagraph (A) if—

''(I) it relates to an externally appealable decision (as defined in subsection (a)(2) of section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999);

''(II) an external appeal with respect to such decision was completed under such section 103;

''(III) in the case such external appeal was initiated by the plan or issuer filing the request for the external appeal, the request was filed on a timely basis before the date the action was brought or, if later, within 30 days after the date the externally appealable decision was made; and

''(IV) the plan or issuer complied with the determination of the external appeal entity upon receipt of the determination of the external appeal entity.

The provisions of this clause supersede any State law or common law to the contrary.

''(ii) EXCEPTION.—Clause (i) shall not apply with respect to damages in the case of a cause of action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such a cause of action which are only punitive or exemplary in nature.

''(C) PERSONAL INJURY DEFINED.—For purposes of this subsection, the term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(2) EXCEPTION FOR GROUP HEALTH PLANS, EMPLOYERS, AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

''(i) any cause of action against a group health plan or an employer or other plan sponsor maintaining the plan (or against an employee of such a plan, employer, or sponsor acting within the scope of employment), or

''(ii) a right of recovery, indemnity, or contribution by a person against a group health plan or an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against group health plan or an employer or other plan sponsor (or against an employee of such a plan, employer, or sponsor acting within the scope of employment) if—

''(i) such action is based on the exercise by the plan, employer, or sponsor (or employee) of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the exercise by the plan, employer, or sponsor (or employee) of such authority resulted in personal injury or wrongful death.

''(C) EXCEPTION.—The exercise of discretionary authority described in subparagraph (B)(i) shall not be construed to include—

''(i) the decision to include or exclude from the plan any specific benefit;

''(ii) any decision to provide extra-contractual benefits; or

''(iii) any decision not to consider the provision of a benefit while internal or external review is being conducted.

''(3) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is required to exhaust administrative processes under sections 102 and 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999, unless the injury to or death of such individual has occurred before the completion of such processes.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved;

''(B) as preempting a State law which requires an affidavit or certificate of merit in a civil action; or

''(C) permitting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A).

''(f) RULES OF CONSTRUCTION RELATING TO HEALTH CARE.—Nothing in this title shall be construed as—

''(1) permitting the application of State laws that are otherwise superseded by this title and that mandate the provision of specific benefits by a group health plan (as defined in section 733(a)) or a multiple employer welfare arrangement (as defined in section 3(40)), or

''(2) affecting any State law which regulates the practice of medicine or provision of medical care, or affecting any action based upon such a State law.''.

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

SEC. 303. LIMITATIONS ON ACTIONS.

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

''(n)(1) Except as provided in this subsection, no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 101, subtitle B, or subtitle D of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as incorporated under section 714).

''(2) An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 101, 113, 114, 115, 116, 117, 119, or 118(3) of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

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

''(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

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

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

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

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

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

and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, 303, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2001 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 201(a), 301, 303, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

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

(B) the general effective date.

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

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

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

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Bipartisan Consensus Managed Care Improvement Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate Government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

The CHAIRMAN. No further amendment is in order except those printed in part B of the report. Each amendment may be offered only in the order printed, may be offered only by a Member designated in the report, shall be considered read, debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment.

The Chairman of the Committee of the Whole may postpone a request for a recorded vote on any amendment and may reduce to a minimum of 5 minutes the time for voting on any postponed question that immediately follows another vote, provided that the time for voting on the first question shall be a minimum of 15 minutes.

It is now in order to consider amendment No. 1 printed in part B of House Report 106–366.

AMENDMENT NO. 1 IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. BOEHNER

Mr. BOEHNER. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 1 in the nature of a substitute offered by Mr. BOEHNER:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Access and Responsibility in Health Care Act of 1999''.

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

Sec. 1. Short title and table of contents.

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

Subtitle A—Patient Protections

Sec. 101. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.

Sec. 102. Required disclosure to network providers.

Sec. 103. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 111. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.-

Sec. 112. Effective date and related rules.

Subtitle C—Group Health Plan Review Standards

Sec. 121. Special rules for group health plans.

Sec. 122. Special rule for access to specialty care.

Sec. 123. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

Sec. 124. Effective date.

Subtitle E—Health Care Access, Affordability, and Quality Commission

Sec. 131. Establishment of commission.

Sec. 132. Effective date.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Sec. 201. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.

Sec. 202. Requiring health maintenance organizations to offer option of point-of-service coverage.

Sec. 203. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 211. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 212. Effective date and related rules.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Sec. 301. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 401. Federal reform of health care liability actions.

Sec. 402. Definitions.

Sec. 403. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 411. Statute of limitations.

Sec. 412. Calculation and payment of damages.

Sec. 413. Alternative dispute resolution.

Sec. 414. Reporting on fraud and abuse enforcement activities.

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

Subtitle A—Patient Protections

SEC. 101. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

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

''SEC. 714. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

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

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

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

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the sponsor of a group health plan or a health insurance issuer offering health insurance coverage in connection with the group health plan to engage in any practice that would violate its religious beliefs or moral convictions.

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

''(1) COVERAGE OF EMERGENCY SERVICES.—

''(A) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to emergency services (as defined in subparagraph (B)(ii)), or ambulance services, the plan or issuer shall cover emergency services (including emergency ambulance services as defined in subparagraph (B)(iii)) furnished under the plan or coverage—

''(i) without the need for any prior authorization determination;

''(ii) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

''(iii) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

''(iv) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 701 and other than applicable cost sharing).

''(B) DEFINITIONS.—In this subsection:

''(i) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(I) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)); and

''(II) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(ii) EMERGENCY SERVICES.—The term 'emergency services' means—

''(I) with respect to an emergency medical condition described in clause (i)(I), a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in clause (i)) and also, within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(II) with respect to an emergency medical condition described in clause (i)(II), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(iii) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in clause (i)) to a hospital for the receipt of emergency services (as defined in clause (ii)) in a case in which appropriate emergency medical screening examinations

are covered under the plan or coverage pursuant to paragraph (1)(A) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''(iv) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(v) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or under group health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(vi) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage offered by a health insurance issuer in connection with such a plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(c) PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE.—

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

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

''(i) gynecological care (such as preventive women's health examinations); or

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

provided by a participating health care professional who specializes in such care (or provides benefits consisting of payment for such care); and

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

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

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

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

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

''(3) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse midwife or nurse practitioner) who is licensed, accredited, or certified under State law to provide obstetric and gynecological health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform obstetric and gynecological health care services. Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(5) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(d) PATIENT RIGHT TO PEDIATRIC CARE.—

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

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse practitioner) who is licensed, accredited, or certified under State law to provide pediatric health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform pediatric health care services. Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''(4) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(e) CONTINUITY OF CARE.—

''(1) IN GENERAL.—

''(A) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, and a health care provider is terminated (as defined in subparagraph (D)(ii)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who, at the time of such termination, is a participant or beneficiary in the plan and is scheduled to undergo surgery (including an organ transplantation), is undergoing treatment for pregnancy, or is determined to be terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act) and is undergoing treatment for the terminal illness, the plan or issuer shall—

''(i) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this subsection; and

''(ii) subject to paragraph (3), permit the individual to elect to continue to be covered with respect to treatment by the provider for such surgery, pregnancy, or illness during a transitional period (provided under paragraph (2)).

''(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this subsection) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(C) TERMINATION DEFINED.—For purposes of this subsection, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(2) TRANSITIONAL PERIOD.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this paragraph shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

''(B) SCHEDULED SURGERY.—If surgery was scheduled for an individual before the date of the announcement of the termination of the provider status under paragraph (1)(A)(i), the transitional period under this paragraph with respect to the surgery shall extend beyond the period under subparagraph (A) and until the date of discharge of the individual after completion of the surgery.

''(C) PREGNANCY.—If—

''(i) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this paragraph with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(D) TERMINAL ILLNESS.—If—

''(i) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination, the transitional period under this paragraph shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under paragraph (1)(A)(i) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(A) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B),

at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

''(B) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under subparagraph (A) and to provide to such plan or issuer necessary medical information related to the care provided.

''(C) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(D) The provider agrees to provide transitional care to all participants and beneficiaries who are eligible for and elect to have coverage of such care from such provider.

''(E) If the provider initiates the termination, the provider has notified the plan within 30 days prior to the effective date of the termination of—

''(i) whether the provider agrees to permissible terms and conditions (as set forth in this paragraph) required by the plan, and

''(ii) if the provider agrees to the terms and conditions, the specific plan beneficiaries and participants undergoing a course of treatment from the provider who the provider believes, at the time of the notification, would be eligible for transitional care under this subsection.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) require the coverage of benefits which would not have been covered if the provider involved remained a participating provider, or

''(B) prohibit a group health plan from conditioning a provider's participation on the provider's agreement to provide transitional care to all participants and beneficiaries eligible to obtain coverage of such care furnished by the provider as set forth under this subsection.

''(f) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraphs (2), (3), and (4), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participation of the participant or beneficiary in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(A)(i) The individual has been diagnosed with cancer.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon satisfaction by the individual of the conditions described in subparagraph (A); or

''(ii) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the satisfaction by the individual of the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(B) ROUTINE PATIENT CARE COSTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'routine patient care costs' shall include the costs associated with the provision of items and services that—

''(I) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(II) are furnished according to the protocol of an approved clinical trial program.

''(ii) EXCLUSION.—For purposes of this paragraph, 'routine patient care costs' shall not include the costs associated with the provision of—

(I) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

(II) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(C) PAYMENT RATE.—For purposes of this subsection—

''(i) PARTICIPATING PROVIDERS.—In the case of covered items and services provided by a participating provider, the payment rate shall be at the agreed upon rate.

''(ii) NONPARTICIPATING PROVIDERS.—In the case of covered items and services provided by a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

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

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's coverage with respect to clinical trials.

''(6) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(A) IN GENERAL.—For purposes of this subsection, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this subsection with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4.

''(7) STUDY AND REPORT.—

''(A) STUDY.—The Secretary shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(i) the cost of patient care in trials versus standard care;

''(ii) the cost effectiveness achieved in different sites of service;

''(iii) research outcomes;

''(iv) volume of research subjects available in different sites of service;

''(v) access to research sites and clinical trials by cancer patients;

''(vi) patient cost sharing or copayment costs realized in different sites of service;

''(vii) health outcomes experienced in different sites of service;

''(viii) long term health care services and costs experienced in different sites of service;

''(ix) morbidity and mortality experienced in different sites of service; and

''(x) patient satisfaction and preference of sites of service.

''(B) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains—

''(i) an assessment of any incremental cost to group health plans resulting from the provisions of this section;

''(ii) a projection of expenditures to such plans resulting from this section;

''(iii) an assessment of any impact on premiums resulting from this section; and

''(iv) recommendations regarding action on other diseases.''.

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

''Sec. 714. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.''.

SEC. 102. REQUIRED DISCLOSURE TO NETWORK PROVIDERS.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by section 101) is amended further by adding at the end the following new section:

"SEC. 715. REQUIRED DISCLOSURE TO NETWORK PROVIDERS.

''(a) IN GENERAL.—If a group health plan reimburses, through a contract or other arrangement, a health care provider at a discounted payment rate because the provider participates in a provider network, the plan shall disclose to the provider the following information before the provider furnishes covered items or services under the plan:

''(1) The identity of the plan sponsor or other entity that is to utilize the discounted payment rates in reimbursing network providers in that network.

''(2) The existence of any substantial benefit differentials established for the purpose of actively encouraging participants or beneficiaries under the plan to utilize the providers in that network.

''(3) The methods and materials by which providers in the network are identified to such participants or beneficiaries as part of the network.

''(b) PERMITTED MEANS OF DISCLOSURE.—Disclosure required under subsection (a) by a plan may be made—

''(1) by another entity under a contract or other arrangement between the plan and the entity; and

''(2) by making such information available in written format, in an electronic format, on the Internet, or on a proprietary computer network which is readily accessible to the network providers.

''(c) CONSTRUCTION.—Nothing in this section shall be construed to require, directly or indirectly, disclosure of specific fee arrangements or other reimbursement arrangements—

''(1) between (i) group health plans or provider networks and (ii) health care providers, or

''(2) among health care providers.

''(d) DEFINITIONS.—For purposes of this subsection:

''(1) BENEFIT DIFFERENTIAL.—The term 'benefit differential' means, with respect to a group health plan, differences in the case of any participant or beneficiary, in the financial responsibility for payment of coinsurance, copayments, deductibles, balance billing requirements, or any other charge, based upon whether a health care provider from whom covered items or services are obtained is a network provider.

''(2) DISCOUNTED PAYMENT RATE.—The term 'discounted payment rate' means, with respect to a provider, a payment rate that is below the charge imposed by the provider.

''(3) NETWORK PROVIDER.—The term 'network provider' means, with respect to a group health plan, a health care provider that furnishes health care items and services to participants or beneficiaries under the plan pursuant to a contract or other arrangement with a provider network in which the provider is participating.

''(4) PROVIDER NETWORK.—The term 'provider network' means, with respect to a group health plan offering health insurance coverage, an association of network providers through whom the plan provides, through contract or other arrangement, health care items and services to participants and beneficiaries.''.

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

''Sec. 715. Required disclosure to network providers.''.

SEC. 103. EFFECTIVE DATE AND RELATED RULES.

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

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

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this subtitle shall not apply with respect to plan years beginning before the later of—

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

(2) January 1, 2002.

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

Subtitle B—Patient Access to Information

SEC. 111. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

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

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

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

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

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

''(1) COVERED ITEMS AND SERVICES.—

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

''(i) types of items and services (including any special disease management program); and

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

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

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

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

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

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

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

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

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

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

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

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

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

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

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

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

''(3) NETWORK CHARACTERISTICS.—If the plan (or health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

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

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

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

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

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions;

''(B) internal review of coverage decisions; and

''(C) any external review of coverage decisions; and

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

''(e) INFORMATION ON PLAN PERFORMANCE.—Any information required under subsection (a) shall include information concerning the number of external reviews under section 503 that have been completed during the prior plan year and the number of such reviews in which a recommendation is made for modification or reversal of an internal review decision under the plan.

''(f) INFORMATION INCLUDED WITH ADVERSE COVERAGE DECISIONS.—A group health plan shall provide to each participant and beneficiary, together with any notification of the participant or beneficiary of an adverse coverage decision, the following information:

''(1) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—A description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in the adverse coverage decision.

''(2) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR ON INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENTS.—If the adverse coverage decision is based on a determination relating to medical necessity or to an investigational item or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(g) INFORMATION AVAILABLE ON REQUEST.—

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

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan may, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format—

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

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

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

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

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

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

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

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

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

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

''(iv) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS.—

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

''(ii) COST OF PROCEDURES.—Any health care professional who recommends an elective procedure or treatment while treating a participant or beneficiary under a group health plan that requires a participant or beneficiary to share in the cost of treatment shall inform such participant or beneficiary of each cost associated with the procedure or treatment and an estimate of the magnitude of such costs.

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

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

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

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

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

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

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

''(j) DEFINITIONS AND RELATED RULES.—

''(1) IN GENERAL.—For purposes of this section—

''(A) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 733(a)(1).

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

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).

''(2) APPLICABILITY ONLY IN CONNECTION WITH INCLUDED GROUP HEALTH PLAN BENEFITS.—

''(A) IN GENERAL.—The requirements of this section shall apply only in connection with included group health plan benefits.

''(B) INCLUDED GROUP HEALTH PLAN BENEFIT.—For purposes of subparagraph (A), the term 'included group health plan benefit' means a benefit which is not an excepted benefit (as defined in section 733(c)).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 112(j)(1)(A)) providing included group health plan benefits (as defined in section 111(j)(2)(B)), the information required to be included under section 111(a)''.

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

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

SEC. 112. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan

years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

Subtitle C—Group Health Plan Review Standards

SEC. 121. SPECIAL RULES FOR GROUP HEALTH PLANS.

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

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

(2) by inserting (after and below paragraph (2)) the following new flush-left sentence: ''This subsection does not apply in the case of included group health plan benefits (as defined in subsection (b)(10)(S)).''; and

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

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

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall, in the case of included group health plan benefits—

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

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

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 90 days after receipt of the notice of the initial decision, for a full and fair review of the decision by an appropriate named fiduciary who did not make the initial decision; and

''(D) meet the additional requirements of this subsection, which shall apply solely with respect to such benefits.

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

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

''(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (10)(I) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

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

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO ACCELERATED NEED MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan before the end of the accelerated need decision period under paragraph (10)(K), in cases involving accelerated need medical care, following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision before the end of the accelerated need decision period under paragraph (10)(K) following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

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

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

''(A) IN GENERAL.—In any case in which a participant or beneficiary, who has received an adverse coverage decision which is not reversed upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) and who has not commenced review of the coverage decision under section 502, makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the requirements of subparagraphs (B), (C), (D) and (E) shall apply in the case of such adverse coverage decision, if the requirements of clause (i) or (ii) are met, subject to clause (iii).

''(i) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEM OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—The requirements of this clause are met if such coverage decision is based on a determination that provision of a particular item or service that would otherwise be covered is excluded from coverage because the provision of such item or service—

''(I) is not medically appropriate or necessary; or

''(II) would constitute provision of an investigational item or experimental treatment or technology.

''(ii) EXCLUSION OF ITEM OR SERVICE REQUIRING EVALUATION OF MEDICAL FACTS OR EVIDENCE.—The requirements of this clause are met if—

''(I) such coverage decision is based on a determination that a particular item or service is not covered under the terms of the plan because provision of such item or service is specifically or categorically excluded from coverage under the terms of the plan, and

''(II) an independent contract expert finds under subparagraph (C), in advance of any review of the decision under subparagraph (D), that such determination primarily requires the evaluation of medical facts or medical evidence by a health professional.

''(iii) MATTERS SPECIFICALLY NOT SUBJECT TO REVIEW.—The requirements of subparagraphs (B), (C), (D), and (E) shall not apply in the case of any adverse coverage decision if such decision is based on—

''(I) a determination of eligibility for benefits,

''(II) the application of explicit plan limits on the number, cost, or duration of any benefit, or

''(III) a limitation on the amount of any benefit payment or a requirement to make copayments under the terms of the plan.

Review under this paragraph shall not be available for any coverage decision that has previously undergone review under this paragraph.

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

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

''(ii) $25,

with such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in

part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert (or panel of such experts) under subparagraph (D)(ii)(IV) is to reverse or modify the coverage decision.

''(C) REQUEST TO INDEPENDENT CONTRACT EXPERT FOR DETERMINATION OF WHETHER COVERAGE DECISION REQUIRED EVALUATION OF MEDICAL FACTS OR EVIDENCE.—

''(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of subparagraph (A)(ii) are met (and review is not otherwise precluded under subparagraph (A)(iii)), the terms of the plan shall provide for a procedure for initial review by an independent contract expert selected in accordance with subparagraph (H) under which the expert will determine whether the coverage decision requires the evaluation of medical facts or evidence by a health professional. If the expert determines that the coverage decision requires such evaluation, reconsideration of such adverse decision shall proceed under this paragraph. If the expert determines that the coverage decision does not require such evaluation, the adverse decision shall remain the final decision of the plan.

''(ii) INDEPENDENT CONTRACT EXPERTS.—For purposes of this subparagraph, the term 'independent contract expert' means a professional—

''(I) who has appropriate credentials and has attained recognized expertise in the applicable area of contract interpretation;

''(II) who was not involved in the initial decision or any earlier review thereof; and

''(III) who is selected in accordance with subparagraph (H)(i) and meets the requirements of subparagraph (H)(iii).

''(D) RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of subparagraph (A)(i) are met or reconsideration proceeds under this paragraph pursuant to subparagraph (C), the terms of the plan shall provide for a procedure for such reconsideration in accordance with clause (ii).

''(ii) PROCEDURE FOR RECONSIDERATION.—The procedure required under clause (i) shall include the following—

''(I) An independent medical expert (or a panel of such experts, as determined necessary) will be selected in accordance with subparagraph (H) to reconsider any coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title.

''(II) The record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert (or panel) and maintained in a manner which will ensure confidentiality of such record.

''(III) Such expert (or panel) will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title. The expert (or panel) in its reconsideration will take into account the medical condition of the patient, the recommendation of the treating physician, the initial coverage decision (including the reasons for such decision) and the decision upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) , any guidelines adopted by the plan through a process involving medical practitioners and peer-reviewed medical literature identified as such under criteria established by the Food and Drug Administration, and any other valid, relevant, scientific or clinical evidence the expert (or panel) determines appropriate for its review. The expert (or panel) may consult the participant or beneficiary, the treating physician, the medical director of the plan, or any other party who, in the opinion of the expert (or panel), may have relevant information for consideration.

''(E) ISSUANCE OF BINDING FINAL DECISION.—Upon completion of the procedure for review under subparagraph (D), the independent medical expert (or panel of such experts) shall issue a written decision affirming, modifying, or reversing the initial review decision, setting forth the grounds for the decision. Such decision shall be the final decision of the plan and shall be binding on the plan. Such decision shall set forth specifically the determination of the expert (or panel) of the appropriate period for timely compliance by the plan with the decision. Such decision shall be issued concurrently to the participant or beneficiary, to the treating physician, and to the plan, shall constitute conclusive, written authorization for the provision of benefits under the plan in accordance with the decision, and shall be treated as terms of the plan for purposes of any action by the participant or beneficiary under section 502.

''(F) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph (including any review under subparagraph (C)) shall be completed before the end of the reconsideration period (as defined in paragraph (10)(L)) following the review filing date in connection with such review. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(G) INDEPENDENT MEDICAL EXPERTS.—

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

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

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

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

''(IV) who has no history of disciplinary action or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, health carrier, government, or regulatory body, and

''(V) who is selected in accordance with subparagraph (H)(i) and meets the requirements of subparagraph (H)(iii).

''(H) SELECTION OF EXPERTS.—

''(i) IN GENERAL.—An independent contract expert or independent medical expert (or each member of any panel of independent medical experts selected under subparagraph (D)(ii)) is selected in accordance with this clause if—

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

''(II) the expert is selected by an appropriately credentialed panel of physicians meeting the requirements of clauses (ii) and (iii) established by a fully accredited teaching hospital meeting such requirements;

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clauses (ii) and (iii);

''(IV) the expert is selected by an external review organization which meets the requirements of clauses (ii) and (iii) and is accredited by a private standard-setting organization meeting such requirements;

''(V) the expert is selected by a State agency which is established for the purpose of conducting independent external reviews and which meets the requirements of clauses (ii) and (iii); or

''(VI) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence, and the method of selection is devised to reasonably ensure that the expert selected meets the requirements of clauses (ii) and (iii).

''(ii) STANDARDS OF PERFORMANCE FOR INTERMEDIARIES.—The Secretary shall prescribe by regulation standards (in addition to the requirements of clause (iii)) which entities making selections under subclause (I), (II), (III), (IV), (V), or (VI) of clause (ii) must meet in order to be eligible for making such selections. Such standards shall include (but are not limited to)—

''(I) assurance that the entity will carry out specified duties in the course of exercising the entity's responsibilities under clause (i)(I),

''(II) assurance that applicable deadlines will be met in the exercise of such responsibilities, and

''(III) assurance that the entity meets appropriate indicators of solvency and fiscal integrity.

Each such entity shall provide to the Secretary, in such manner and at such times as the Secretary may prescribe, information relating the volume of claims with respect to which the entity has served under this subparagraph, the types of such claims, and such other information regarding such claims as the Secretary may determine appropriate.

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

''(I) the expert or entity is not affiliated with any related party;

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

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

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

''(iv) RELATED PARTY.—For purposes of clause (i)(I), the term 'related party' means—

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

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

''(III) the institution at which the medical care involved in the coverage decision is provided;

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

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

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

''(I) MISBEHAVIOR BY EXPERTS.—Any action by the expert or experts in applying for their selection under this paragraph or in the course of carrying out their duties under this paragraph which constitutes—

''(i) fraud or intentional misrepresentation by such expert or experts, or

''(ii) demonstrates failure to adhere to the standards for selection set forth in subparagraph (H)(iii),

shall be treated as a failure to meet the requirements of this paragraph and therefore as a cause of action which may be brought by a fiduciary under section 502(a)(3).

''(J) BENEFIT EXCLUSIONS MAINTAINED.—Nothing in this paragraph shall be construed as providing for or requiring the coverage of items or services for which benefits are specifically excluded under the group health plan or any health insurance coverage offered in connection with the plan.

''(5) PERMITTED ALTERNATIVES TO REQUIRED FORMS OF REVIEW.—

''(A) IN GENERAL.—In accordance with such regulations (if any) as may be prescribed by the Secretary for purposes of this paragraph, in the case of any initial coverage decision or any decision upon review thereof under paragraph (2)(A)(ii) or (2)(B)(ii), a group health plan may provide an alternative dispute resolution procedure meeting the requirements of subparagraph (B) for use in lieu of the procedures set forth under the preceding provisions of this subsection relating review of such decision. Such procedure may be provided in one form for all participants and beneficiaries or in a different form for each group of similarly situated participants and beneficiaries. Upon voluntary election of such procedure by the plan and by the aggrieved participant or beneficiary in connection with the decision, the plan may provide under such procedure (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) for waiver of the review of the decision under paragraph (3) or waiver of further review of the decision under paragraph (4) or section 502 or for election by such parties of an alternative means of external review (other than review under paragraph (4)).

''(B) REQUIREMENTS.—An alternative dispute resolution procedure meets the requirements of this subparagraph, in connection with any decision, if—

''(i) such procedure is utilized solely—

''(I) in accordance with the applicable terms of a bona fide collective bargaining agreement pursuant to which the plan (or the applicable portion thereof governed by the agreement) is established or maintained, or

''(II) upon election by both the aggrieved participant or beneficiary and the plan,

''(ii) the procedure incorporates any otherwise applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures); and

''(iii) the means of resolution of dispute allow for adequate presentation by each party of scientific and medical evidence supporting the position of such party.

''(6) REVIEW REQUIREMENTS.—In any review of a decision issued under this subsection—

''(A) the record shall be maintained for purposes of any further review in accordance with standards which shall be prescribed in regulations of the Secretary designed to facilitate such further review, and

''(B) any decision upon review which modifies or reverses a decision below shall specifically set forth a determination that the record upon review is sufficient to rebut a presumption in favor of the decision below.

''(7) COMPLIANCE WITH FIDUCIARY STANDARDS.—The issuance of a decision under a plan upon review in good faith compliance with the requirements of this subsection shall not be treated as a violation of part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(8) LIMITATION ON APPLICABILITY OF SPECIAL RULES.—The provisions of this subsection shall not apply with respect to employee benefit plans that are not group health plans or with respect to benefits that are not included group health plan benefits (as defined in paragraph (10)(S)).

''(9) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

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

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

''(10) OTHER DEFINITIONS.—For purposes of this subsection—

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

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

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

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

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes accelerated need medical care.

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

''(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes accelerated need medical care.

''(H) ACCELERATED NEED MEDICAL CARE.—The term 'accelerated need medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that the participant or beneficiary is stabilized and—

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

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

''(II) serious impairment to bodily functions; or

''(III) serious dysfunction of any bodily organ or part; or

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

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

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

''(K) ACCELERATED NEED DECISION PERIOD.—The term 'accelerated need decision period' means a period of 3 days, or such period as may be prescribed in regulations of the Secretary.

''(L) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such period as may be prescribed in regulations of the Secretary, except that, in the case of a decision involving accelerated need medical care, such term means the accelerated need decision period.

''(M) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

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

''(O) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(P) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(Q) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(R) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a

generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

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

''(S) INCLUDED GROUP HEALTH PLAN BENEFIT.—The term 'included group health plan benefit'' means a benefit under a group health plan which is not an excepted benefit (as defined in section 733(c)).''.

(b) CIVIL PENALTIES.—

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

''(6)(A)(i) In the case of any failure to timely provide an included group health plan benefit (as defined in section 503(b)(10)(S)) to a participant or beneficiary, which occurs after the issuance of, and in violation of, a final decision rendered upon completion of external review (under section 503(b)(4)) of an adverse coverage decision by the plan relating to such benefit, any person acting in the capacity of a fiduciary of the plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Except as provided in clause (iii), such civil penalty shall be in an amount of up to $1,000 a day from the date that occurs on or after the date of the issuance of the decision under section 503(b)(4) and upon which the plan otherwise could have been reasonably expected to commence compliance with the decision until the date the failure to provide the benefit is corrected.

''(iii) In any case in which it is proven by clear and convincing evidence that the person referred to in clause (i) acted willfully and in bad faith, the daily penalty under clause (ii) shall be increased to an amount of up to $5,000 a day.

''(iv) In any case in which it is further proven by clear and convincing evidence that—

''(I) the plan is not in full compliance with the decision of the independent medical expert (or panel of such experts) under section 503(b)(4)(E)) within the appropriate period specified in such decision, and

''(II) the failure to be in full compliance was caused by the plan or by a health insurance issuer offering health insurance coverage in connection with the plan,

the plan shall pay the cost of all medical care which was not provided by reason of such failure to fully comply and which is otherwise obtained by the participant or beneficiary from any provider.

''(B) For purposes of subparagraph (A), the plan, and any health insurance issuer offering health insurance coverage in connection with the plan, shall be deemed to be in compliance with any decision of an independent medical expert (or panel of such experts) under section 503(b)(4) with respect to any participant or beneficiary upon transmission to such entity (or panel) and to such participant or beneficiary by the plan or issuer of timely notice of an authorization of coverage by the plan or issuer which is consistent with such decision.

''(C) In any action commenced under subsection (a) by a participant or beneficiary with respect to an included group health plan benefit in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act; and

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

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

''(D)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of one or more group health plans (as defined in section 503(b)(9)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in connection with included group health plan benefits in violation of the terms of the plan or plans or this title; or

''(II) any pattern or practice of repeated violations of the requirements of section 503 in connection with such benefits.

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

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

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

''(II) $100,000.

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

''(E) For purposes of this paragraph, the term 'included group health plan benefit' has the meaning provided in section 503(b)(10)(S).

''(F) The preceding provisions of this paragraph shall not apply with respect to employee benefit plans that are not group health plans or with respect to benefits that are not included group health plan benefits (as defined in paragraph (10)(S)).''.

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

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

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

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

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

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

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

''(4) In the case of a group health plan, if exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by the participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action. This paragraph shall not apply with respect to benefits that are not included group health plan benefits (as defined in section 503(b)(10)(S)).''.

(d) ATTORNEY'S FEES.—Section 502(g) of such Act (29 U.S.C. 1132(g)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraph (2) or (3))''; and

(2) by adding at the end the following new paragraph:

''(3) In any action under this title by a participant or beneficiary in connection with an included group health plan benefit (as defined in section 503(b)(10)(S)) in which judgment in favor of the participant or beneficiary is awarded, the court shall allow a reasonable attorney's fee and costs of action to the participant or beneficiary.''.

(e) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

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

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

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

SEC. 122. SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.

Section 503(b) of such Act (as added by the preceding provisions of this subtitle) is amended by adding at the end the following new paragraph:

''(11) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.—

''(A) IN GENERAL.—In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the accelerated need decision period.

''(B) SPECIALIST.—For purposes of this paragraph, the term 'specialist' means, with

respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a patient who is a child, appropriate pediatric expertise) to treat the condition.''.

SEC. 123. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 124. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by sections 801 and 802 shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following 12 months after the date the Secretary of Labor issues all regulations necessary to carry out amendments made by this title. The amendments made by section 803 shall take effect on such January 1.

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

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

Subtitle D—Health Care Access, Affordability, and Quality Commission

SEC. 131. ESTABLISHMENT OF COMMISSION.

Part 5 of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 518. HEALTH POLICY COMMISSION.

''(a) ESTABLISHMENT.—There is hereby established a commission to be known as the Health Care Access, Affordability, and Quality Commission (hereinafter in this Act referred to as the ''Commission'').

''(b) DUTIES OF COMMISSION.—The duties of the Commission shall be as follows:

''(1) STUDIES OF CRITICAL AREAS.—Based on information gathered by appropriate Federal agencies, advisory groups, and other appropriate sources for health care information, studies, and data, the Commission shall study and report on in each of the following areas:

''(A) Independent expert external review programs.

''(B) Consumer friendly information programs.

''(C) The extent to which the following affect patient quality and satisfaction:

''(i) health plan enrollees' attitudes based on surveys;

''(ii) outcomes measurements; and

''(iii) accreditation by private organizations.

''(D) Available systems to ensure the timely processing of claims.

''(2) ESTABLISHMENT OF FORM FOR REMITTANCE OF CLAIMS TO PROVIDERS.—Not later than 2 years after the date of the first meeting of the Commission, the Commission shall develop and transmit to the Secretary a proposed form for use by health insurance issuers (as defined in section 733(b)(2)) for the remittance of claims to health care providers. Effective for plan years beginning after 5 years after the date of the Comprehensive Access and Responsibility in Health Care Act of 1999, a health insurance issuer offering health insurance coverage in connection with a group health plan shall use such form for the remittance of all claims to providers.

''(3) EVALUATION OF HEALTH BENEFITS MANDATES.—At the request of the chairmen or ranking minority members of the appropriate committees of Congress, the Commission shall evaluate, taking into consideration the overall cost effect, availability of treatment, and the effect on the health of the general population, existing and proposed benefit requirements for group health plans.

''(4) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to policies under this section, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(5) AGENDA AND ADDITIONAL REVIEW.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress toward achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics as may be requested by such chairmen and members and as the Commission deems appropriate.

''(6) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include—

''(i) physicians and other health professionals;

''(ii) representatives of employers, including multiemployer plans;

''(ii) representatives of insured employees;

''(iv) third-party payers; and

''(v) health services and health economics researchers with expertise in outcomes and effectiveness research and technology assessment.

''(B) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—Each member shall be appointed for a term of 3 years, except that the Comptroller shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(4) BASIC PAY.—

''(A) RATES OF PAY.—Except as provided in subparagraph (B), members shall each be paid at a rate equal to the rate of basic pay payable for level IV of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Commission.

''(B) PROHIBITION OF COMPENSATION OF FEDERAL EMPLOYEES.—Members of the Commission who are full-time officers or employees of the United States (or Members of Congress) may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

''(5) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

''(6) CHAIRPERSON.—The Chairperson of the Commission shall be designated by the Comptroller at the time of the appointment. The term of office of the Chairperson shall be 3 years.

''(7) MEETINGS.—The Commission shall meet 4 times each year.

''(d) DIRECTOR AND STAFF OF COMMISSION.—

''(1) DIRECTOR.—The Commission shall have a Director who shall be appointed by the Chairperson. The Director shall be paid at a rate not to exceed the maximum rate of

basic pay payable for GS–13 of the General Schedule.

''(2) STAFF.—The Director may appoint 2 additional staff members.

''(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The Director and staff of the Commission shall be appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates.

''(e) POWERS OF COMMISSION.—

''(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

''(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

''(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

''(4) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

''(6) CONTRACT AUTHORITY.—The Commission may contract with and compensate government and private agencies or persons for services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) REPORTS.—Beginning December 31, 2000, and each year thereafter, the Commission shall submit to the Congress an annual report detailing the following information:

''(1) Access to care, affordability to employers and employees, and quality of care under employer-sponsored health plans and recommendations for improving such access, affordability, and quality.

''(2) Any issues the Commission deems appropriate or any issues (such as the appropriateness and availability of particular medical treatment) that the chairmen or ranking members of the appropriate committees of Congress requested the Commission to evaluate.

''(g) DEFINITION OF APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section the term 'appropriate committees of Congress' means any committee in the Senate or House of Representatives having jurisdiction over the Employee Retirement Income Security Act of 1974.

''(h) TERMINATION.—Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the Commission.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for fiscal years 2000 through 2004 such sums as may be necessary to carry out this section.''.

SEC. 132. EFFECTIVE DATE.

This subtitle shall be effective 6 months after the date of the enactment of this Act.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 201. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

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

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

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

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the sponsor of a group health plan or a health insurance issuer offering health insurance coverage in connection with the group health plan to engage in any practice that would violate its religious beliefs or moral convictions.

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

''(1) COVERAGE OF EMERGENCY SERVICES.—

''(A) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to emergency services (as defined in subparagraph (B)(ii)), or ambulance services, the plan or issuer shall cover emergency services (including emergency ambulance services as defined in subparagraph (B)(iii)) furnished under the plan or coverage—

''(i) without the need for any prior authorization determination;

''(ii) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

''(iii) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider, the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

''(iv) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 and other than applicable cost sharing).

''(B) DEFINITIONS.—In this subsection:

''(i) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(I) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)); and

''(II) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(ii) EMERGENCY SERVICES.—The term 'emergency services' means—

''(I) with respect to an emergency medical condition described in clause (i)(I), a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in clause (i)) and also, within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(II) with respect to an emergency medical condition described in clause (i)(II), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(iii) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in clause (i)) to a hospital for the receipt of emergency services (as defined in clause (ii)) in a case in which appropriate emergency medical screening examinations are covered under the plan or coverage pursuant to paragraph (1)(A) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''(iv) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur

during the transfer of the individual from a facility.

''(v) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or under group health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(vi) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage offered by a health insurance issuer in connection with such a plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(c) PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE.—

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

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

''(i) gynecological care (such as preventive women's health examinations); or

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

provided by a participating health care professional who specializes in such care (or provides benefits consisting of payment for such care); and

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

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

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

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

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

''(3) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse midwife or nurse practitioner) who is licensed, accredited, or certified under State law to provide obstetric and gynecological health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform obstetric and gynecological health care services. Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(5) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(d) PATIENT RIGHT TO PEDIATRIC CARE.—

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

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse practitioner) who is licensed, accredited, or certified under State law to provide pediatric health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform pediatric health care services. Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''(4) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(e) CONTINUITY OF CARE.—

''(1) IN GENERAL.—

''(A) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, and a health care provider is terminated (as defined in subparagraph (D)(ii)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who, at the time of such termination, is a participant or beneficiary in the plan and is scheduled to undergo surgery (including an organ transplantation), is undergoing treatment for pregnancy, or is determined to be terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act) and is undergoing treatment for the terminal illness, the plan or issuer shall—

''(i) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this subsection; and

''(ii) subject to paragraph (3), permit the individual to elect to continue to be covered with respect to treatment by the provider for such surgery, pregnancy, or illness during a transitional period (provided under paragraph (2)).

''(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this subsection) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(C) TERMINATION DEFINED.—For purposes of this subsection, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(2) TRANSITIONAL PERIOD.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this paragraph shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

''(B) SCHEDULED SURGERY.—If surgery was scheduled for an individual before the date of the announcement of the termination of the provider status under paragraph (1)(A)(i), the transitional period under this paragraph with respect to the surgery shall extend beyond the period under subparagraph (A) and until the date of discharge of the individual after completion of the surgery.

''(C) PREGNANCY.—If—

''(i) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this paragraph with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(D) TERMINAL ILLNESS.—If—

''(i) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this paragraph shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under paragraph (1)(A)(i) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(A) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

''(B) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under subparagraph (A) and to provide to such plan or issuer necessary medical information related to the care provided.

''(C) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization

and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(D) The provider agrees to provide transitional care to all participants and beneficiaries who are eligible for and elect to have coverage of such care from such provider.

''(E) If the provider initiates the termination, the provider has notified the plan within 30 days prior to the effective date of the termination of—

''(i) whether the provider agrees to permissible terms and conditions (as set forth in this paragraph) required by the plan, and

''(ii) if the provider agrees to the terms and conditions, the specific plan beneficiaries and participants undergoing a course of treatment from the provider who the provider believes, at the time of the notification, would be eligible for transitional care under this subsection.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) require the coverage of benefits which would not have been covered if the provider involved remained a participating provider, or

''(B) prohibit a group health plan from conditioning a provider's participation on the provider's agreement to provide transitional care to all participants and beneficiaries eligible to obtain coverage of such care furnished by the provider as set forth under this subsection.

''(f) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage) provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraphs (2), (3), and (4), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participation of the participant or beneficiary in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(A)(i) The individual has been diagnosed with cancer.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon satisfaction by the individual of the conditions described in subparagraph (A); or

''(ii) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the satisfaction by the individual of the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—A group health plan (or a health insurance issuer offering health insurance coverage) shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(B) ROUTINE PATIENT CARE COSTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'routine patient care costs' shall include the costs associated with the provision of items and services that—

''(I) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(II) are furnished according to the protocol of an approved clinical trial program.

''(ii) EXCLUSION.—For purposes of this paragraph, 'routine patient care costs' shall not include the costs associated with the provision of—

''(I) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(II) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(C) PAYMENT RATE.—For purposes of this subsection—

''(i) PARTICIPATING PROVIDERS.—In the case of covered items and services provided by a participating provider, the payment rate shall be at the agreed upon rate.

''(ii) NONPARTICIPATING PROVIDERS.—In the case of covered items and services provided by a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

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

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's coverage with respect to clinical trials.

''(6) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(A) IN GENERAL.—For purposes of this subsection, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this subsection with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(7) STUDY AND REPORT.—

''(A) STUDY.—The Secretary shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(i) the cost of patient care in trials versus standard care;

''(ii) the cost effectiveness achieved in different sites of service;

''(iii) research outcomes;

''(iv) volume of research subjects available in different sites of service;

''(v) access to research sites and clinical trials by cancer patients;

''(vi) patient cost sharing or copayment costs realized in different sites of service;

''(vii) health outcomes experienced in different sites of service;

''(viii) long term health care services and costs experienced in different sites of service;

''(ix) morbidity and mortality experienced in different sites of service; and

''(x) patient satisfaction and preference of sites of service.

''(B) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains—

''(i) an assessment of any incremental cost to group health plans resulting from the provisions of this section;

''(ii) a projection of expenditures to such plans resulting from this section;

''(iii) an assessment of any impact on premiums resulting from this section; and

''(iv) recommendations regarding action on other diseases.''.

SEC. 202. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)); and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the

group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

''(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

''(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

''(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

''(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization; and

''(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every 2 years.

''(4) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

''(5) SMALL ISSUERS.—Subsections (a) and (b) shall not apply in the case of a health insurance issuer with 25,000 or fewer covered lives.

''(d) APPLICABILITY.—The requirements of this section shall apply only in connection with included group health plan benefits.

''(e) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2707(a)(2).

''(3) INCLUDED GROUP HEALTH PLAN BENEFIT.—The term 'included group health plan benefit' means a benefit which is not an excepted benefit (as defined in section 2791(c)).''.

SEC. 203. EFFECTIVE DATE AND RELATED RULES.

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

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

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this title shall not apply with respect to plan years beginning before the later of—

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

(2) January 1, 2002.

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

Subtitle B—Patient Access to Information

SEC. 111. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A) is amended further by adding at the end the following new section:

''SEC. 2708. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the plan administrator on a timely basis with the information necessary to enable the administrator to provide participants and beneficiaries with information in a manner and to an extent consistent with the requirements of section 111 of the Employee Retirement Income Security Act of 1974. To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

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

''(1) COVERED ITEMS AND SERVICES.—

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

''(i) types of items and services (including any special disease management program); and

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

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

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

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

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

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

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

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

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

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

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

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

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

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

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

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

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

care providers and with respect to specialists.

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

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

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

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan of the type described in section 503 of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions;

''(B) internal review of coverage decisions; and

''(C) any external review of coverage decisions; and

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

''(e) INFORMATION ON PLAN PERFORMANCE.—Any information required under subsection (a) shall include information concerning the number of external reviews of the type described in section 503 of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which a recommendation is made for modification or reversal of an internal review decision under the plan.

''(f) INFORMATION INCLUDED WITH ADVERSE COVERAGE DECISIONS.—A health insurance issuer offering health insurance coverage in connection with a group health plan shall provide to each participant and beneficiary, together with any notification of the participant or beneficiary of an adverse coverage decision, the following information:

''(1) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—A description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in the adverse coverage decision.

''(2) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR ON INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENTS.—If the adverse coverage decision is based on a determination relating to medical necessity or to an investigational item or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(g) INFORMATION AVAILABLE ON REQUEST.—

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

''(A) IN GENERAL.—A health insurance issuer offering health insurance coverage in connection with a group health plan may, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format—

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

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

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

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

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

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

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

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

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

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

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

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS.—

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

''(ii) COST OF PROCEDURES.—Any health care professional who recommends an elective procedure or treatment while treating a participant or beneficiary under a group health plan that requires a participant or beneficiary to share in the cost of treatment shall inform such participant or beneficiary of each cost associated with the procedure or treatment and an estimate of the magnitude of such costs.

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

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

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

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

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

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

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

''(j) DEFINITIONS AND RELATED RULES.—

''(1) IN GENERAL.—For purposes of this section—

''(A) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 733(a)(1).

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

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).

''(2) APPLICABILITY ONLY IN CONNECTION WITH INCLUDED GROUP HEALTH PLAN BENEFITS.—

''(A) IN GENERAL.—The requirements of this section shall apply only in connection with included group health plan benefits.

''(B) INCLUDED GROUP HEALTH PLAN BENEFIT.—For purposes of subparagraph (A), the term 'included group health plan benefit' means a benefit which is not an excepted benefit (as defined in section 2791(c)).''.

SEC. 212. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by section 211 shall apply with respect to plan

years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title before such date.

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

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

SEC. 301. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

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

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

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care, and continuity of care.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE, AND CONTINUITY OF CARE.

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

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

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

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the sponsor of a group health plan to engage in any practice that would violate its religious beliefs or moral convictions.

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

''(1) COVERAGE OF EMERGENCY SERVICES.—

''(A) IN GENERAL.—If a group health plan provides any benefits with respect to emergency services (as defined in subparagraph (B)(ii)), or ambulance services, the plan shall cover emergency services (including emergency ambulance services as defined in subparagraph (B)(iii)) furnished under the plan—

''(i) without the need for any prior authorization determination;

''(ii) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

''(iii) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider; and

''(iv) without regard to any other term or condition of such plan (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 701 and other than applicable cost sharing).

''(B) DEFINITIONS.—In this subsection:

''(i) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(I) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)); and

''(II) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

''(ii) EMERGENCY SERVICES.—The term 'emergency services' means—

''(I) with respect to an emergency medical condition described in clause (i)(I), a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd)) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in clause (i)) and also, within the capabilities of the staff and facilities at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(II) with respect to an emergency medical condition described in clause (i)(II), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(iii) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in clause (i)) to a hospital for the receipt of emergency services (as defined in clause (ii)) in a case in which appropriate emergency medical screening examinations are covered under the plan pursuant to paragraph (1)(A) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''(iv) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(v) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that is not a participating health care provider with respect to such items and services.

''(vi) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan.

''(c) PATIENT RIGHT TO OBSTETRIC AND GYNECOLOGICAL CARE.—

''(1) IN GENERAL.—In any case in which a group health plan—

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

''(i) gynecological care (such as preventive women's health examinations); or

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

provided by a participating health care professional who specializes in such care (or provides benefits consisting of payment for such care); and

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

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

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

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

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

''(3) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse midwife or nurse practitioner) who is licensed, accredited, or certified under State law to provide obstetric and gynecological health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform obstetric and gynecological health care services. Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(5) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(d) PATIENT RIGHT TO PEDIATRIC CARE.—

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

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'health care professional' means an individual (including, but not limited to, a nurse practitioner) who is licensed, accredited, or certified under State law to provide pediatric health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing a plan from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform pediatric health care services. Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''(4) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of this subsection shall apply separately with respect to each coverage option.

''(e) CONTINUITY OF CARE.—

''(1) IN GENERAL.—

''(A) TERMINATION OF PROVIDER.—If a contract between a group health plan and a health care provider is terminated (as defined in subparagraph (D)(ii)), or benefits provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who, at the time of such termination, is a participant or beneficiary in the plan and is scheduled to undergo surgery (including an organ transplantation), is undergoing treatment for pregnancy, or is determined to be terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act) and is undergoing treatment for the terminal illness, the plan shall—

''(i) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this subsection; and

''(ii) subject to paragraph (3), permit the individual to elect to continue to be covered with respect to treatment by the provider for such surgery, pregnancy, or illness during a transitional period (provided under paragraph (2)).

''(B) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of subparagraph (A) (and the succeeding provisions of this subsection) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(C) TERMINATION DEFINED.—For purposes of this subsection, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(2) TRANSITIONAL PERIOD.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this paragraph shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

''(B) SCHEDULED SURGERY.—If surgery was scheduled for an individual before the date of the announcement of the termination of the provider status under paragraph (1)(A)(i), the transitional period under this paragraph with respect to the surgery or transplantation.

''(C) PREGNANCY.—If—

''(i) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(ii) the provider was treating the pregnancy before date of the termination,

the transitional period under this paragraph with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(D) TERMINAL ILLNESS.—If—

''(i) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this paragraph shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan may condition coverage of continued treatment by a provider under paragraph (1)(A)(i) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(A) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in paragraph (1)(B), at the rates applicable under the replacement plan after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in paragraph (1)(A) had not been terminated.

''(B) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under subparagraph (A) and to provide to such plan necessary medical information related to the care provided.

''(C) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(D) The provider agrees to provide transitional care to all participants and beneficiaries who are eligible for and elect to have coverage of such care from such provider.

''(E) If the provider initiates the termination, the provider has notified the plan within 30 days prior to the effective date of the termination of—

''(i) whether the provider agrees to permissible terms and conditions (as set forth in this paragraph) required by the plan, and

''(ii) if the provider agrees to the terms and conditions, the specific plan beneficiaries and participants undergoing a course of treatment from the provider who the provider believes, at the time of the notification, would be eligible for transitional care under this subsection.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) require the coverage of benefits which would not have been covered if the provider involved remained a participating provider, or

''(B) prohibit a group health plan from conditioning a provider's participation on the provider's agreement to provide transitional care to all participants and beneficiaries eligible to obtain coverage of such care furnished by the provider as set forth under this subsection.

''(f) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan provides coverage to a qualified individual (as defined in paragraph (2)), the plan—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraphs (2), (3), and (4), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participation of the participant or beneficiary in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(A)(i) The individual has been diagnosed with cancer.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon satisfaction by the individual of the conditions described in subparagraph (A); or

''(ii) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the satisfaction

by the individual of the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—A group health plan shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(B) ROUTINE PATIENT CARE COSTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'routine patient care costs' shall include the costs associated with the provision of items and services that—

''(I) would otherwise be covered under the group health plan if such items and services were not provided in connection with an approved clinical trial program; and

''(II) are furnished according to the protocol of an approved clinical trial program.

''(ii) EXCLUSION.—For purposes of this paragraph, 'routine patient care costs' shall not include the costs associated with the provision of—

(I) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

(II) any item or service supplied without charge by the sponsor of the approved clinical trial program.

''(C) PAYMENT RATE.—For purposes of this subsection—

''(i) PARTICIPATING PROVIDERS.—In the case of covered items and services provided by a participating provider, the payment rate shall be at the agreed upon rate.

''(ii) NONPARTICIPATING PROVIDERS.—In the case of covered items and servicesprovided by a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

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

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's coverage with respect to clinical trials.

''(6) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(A) IN GENERAL.—For purposes of this subsection, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this subsection with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(7) STUDY AND REPORT.—

''(A) STUDY.—The Secretary shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(i) the cost of patient care in trials versus standard care;

''(ii) the cost effectiveness achieved in different sites of service;

''(iii) research outcomes;

''(iv) volume of research subjects available in different sites of service;

''(v) access to research sites and clinical trials by cancer patients;

''(vi) patient cost sharing or copyament costs realized in different sites of service;

''(vii) health outcomes experienced in different sites of service;

''(viii) long term health care services and costs experienced in different sites of service;

''(ix) morbidity and mortality experienced in different sites of service; and

''(x) patient satisfaction and preference of sites of service.

''(B) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains—

''(i) an assessment of any incremental cost to group health plans resulting from the provisions of this section;

''(ii) a projection of expenditures to such plans resulting from this section;

''(iii) an assessment of any impact on premiums resulting from this section; and

''(iv) recommendations regarding action on other diseases.''.

SEC. 302. EFFECTIVE DATE AND RELATED RULES.

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

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

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this title shall not apply with respect to plan years beginning before the later of—

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

(2) January 1, 2002.

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

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 401. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action;

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.); or

(3) an action in connection with benefits which are not included group health plan benefits (as defined in section 402(14)).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 402. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means

any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate;

(B) a hospital or medical service plan contract;

(C) a health maintenance subscriber contract; or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider;

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit); or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) INCLUDED GROUP HEALTH PLAN BENEFIT.—The term 'included group health plan benefit' means a benefit under a group health plan which is not an excepted benefit (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974).

(15) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(16) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(17) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(18) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce; or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(19) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(20) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 403. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court; and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 411. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 412. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 412(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm; or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages.

(3) LIMITATION ON PUNITIVE DAMAGES.—The total amount of punitive damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed the greater of—

(A) 2 times the amount of economic damages, or

(B) $250,000,

regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a

separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant; or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 413. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

SEC. 414. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to that guideline; and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines; and

(2) submit a report on such compliance to the Committee on Commerce, the Committee on the Judiciary, and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 2000, and every year thereafter for a period of 4 years ending February 1, 2003.

The CHAIRMAN. Pursuant to House Resolution 323, the gentleman from Ohio (Mr. BOEHNER) and the gentleman from Michigan (Mr. DINGELL) will each control 30 minutes.

The Chair recognizes the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, let us stop and ask ourselves a basic question: Just what is health care reform all about? Is it forcing HMOs to be more accountable? Is it expanding access for the 44 million who do not have health coverage? Is it limiting costs and making coverage more affordable?

The answer to all of these questions is yes. Health care reform is about all of these things, access, accountability, and affordability, and we cannot address one without affecting the others; and if we truly want to help patients, we certainly cannot address one at the expense of the other two.

Mr. Chairman, I have the utmost respect for my colleague the gentleman from Michigan (Mr. DINGELL) and my colleague the gentleman from Georgia (Mr. NORWOOD), and I know they believe they found the prescription for what is ailing our health system. But, in truth, I believe their bill is poison for our health care system today.

In an effort to make managed care more accountable, the Dingell-Norwood proposal would authorize lawsuits against health plans. The trouble is most health plans in America are employer-based. More than 124 million Americans get their health coverage through the workplace, a benefit employers can provide voluntarily, thanks to a law known as ERISA, which shields employers from unnecessary litigation. The system, for all its complexity, has saved countless American lives.

Under the Dingell-Norwood proposal though, that would change. Expanding lawsuits against employer-based health plans means expanding lawsuits against employers. If employers are exposed to lawsuits, they are going to stop providing coverage to their employees.

It means millions of American workers are going to lose their health insurance at the very time Congress should be working on expanding access to coverage.

The Dingell-Norwood bill has other flaws. The authors claim their bill is about giving control to doctors and patients, but it is also about giving control to the Federal Government.

Under their proposal, the Department of Labor, the Department of Health and Human Services, the IRS, and likely the States, would all have a hand in regulating Americans' health benefits. Granting the bureaucracy these new powers is another quiet step toward the government-run health care system Americans overwhelmingly rejected in 1993 and 1994. They were right to reject it then, and they would be right in rejecting it now.

Their proposal has a third gaping flaw, and it concerns something that is not even in the bill at all, and that is medical malpractice reform. Our opponents often cite the experience in Texas and what they have done with their HMO liability reform bill, and in fact there have not been a flood of frivolous lawsuits and exploding costs. But what our colleagues never mention is that Texas passed a sweeping medical malpractice and tort reform law 2 years before they passed their HMO liability. Why should this Congress not do the same?

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Mr. Chairman, Americans want health care reform. But legislation that exposes employers to lawsuits jeopardizes the benefits to 124 million American lives who get their coverage from their workplace. It expands the reach of big government and slams the door of medical tort reform, and I am not sure that that is what Americans really want when they think about health care reform today.

Fortunately, there is an alternative. My substitute, the CARE Act, would punish bad HMOs without punishing

the uninsured. We named it the CARE Act because patients want access to care, not access to court. But that does not mean that managed care companies get a free ride. Instead of lawsuits, the CARE Act would guarantee patients the protection of a strong, enforceable and legally binding appeals process.

If you or your family is denied care, you can automatically appeal to independent physicians who are familiar with your case and conditions and are completely independent from the HMO. Assuming the physicians rule in your favor, you get the care; there is no delay, period. You have the right to that care and can get it immediately. And if your plan refuses to do what the doctors order, the plan is subject up to $5,000 per day until you get the care, with no caps.

Now, Mr. Chairman, if we really want to get tough on HMOs that wrongly deny care, I do not think it gets much tougher than that. But here is the best part. Under our CARE Act, HMOs are punished for the wrongful denials before a patient is harmed, instead of after the fact when it is too late. Instead of waiting until a tragic mistake is made, it ensures that patients get the care they need when they need it, and is that not really what managed care reform is all about?

External review gives patients a better option. It also gives us as Members of Congress the chance to be consistent. How can 286 Members of Congress vote to cap Y2K liability for high-tech companies, and then change course and vote for expanded lawsuits in health care? How can three-fourths of the House vote to override the President's veto of securities litigation reform and then turn around and vote to support new lawsuits against employers? How can Members vote for medical malpractice reform six times in the last 5 years in this House that shields providers from lawsuits and then reverse themselves and support expanded liability in health care?

The CARE Act is not just an alternative to lawsuits, Mr. Chairman, it is a better idea altogether.

So I ask my colleagues, for the sake of the 124 million Americans in employer-based health care, give this plan a chance. And for the sake of the 44 million Americans who have no health insurance, give this option a chance. For the sake of our kids and our grandkids whose quality of life will depend on the health care system of the 21st century, give this option a chance.

I urge my colleagues to join me in voting to give patients care, not court. Let us not jeopardize the health insurance benefits our constituents enjoy today from their employers.

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

Mr. DINGELL. Mr. Chairman, I yield myself 2 minutes.

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

Mr. DINGELL. Mr. Chairman, this is a wonderful amendment, but unfortunately, it is a sham and an optical illusion, and very frankly, a fraud. The benefits look good, but there is no way that one can obtain them. Every other alternative to the Norwood-Dingell-Ganske bill that we will consider at least pretends to give you the ability to hold the health insurance companies accountable when they make a medical decision that hurts you. This one does not even keep up the pretense.

The bill is not a serious effort. If you buy insurance, the bill does not help you; and if you have a chronic or serious medical condition requiring regular treatment by a specialist, the bill does not help you. If you believe you should get care when it is medically necessary, this bill does not help you.

For the rhetoric that we are about to hear about lawyers taking over health care and the health care profession, this bill would hand the lawyer, and not the doctor, the power to decide when one needs medical evaluation.

These are just a few of the flaws contained in the Boehner substitute. I urge my colleagues to reject it. I say that with all respect for my good friend, the author of this unfortunate proposal.

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

Mr. BOEHNER. Mr. Chairman, I yield 3 minutes to the gentleman from Virginia (Mr. BLILEY), the chairman of the Committee on Commerce.

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

Mr. BLILEY. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, we need care, not courts. The Boehner bill does that. It allows for binding external review; and if the plan does not accept that, if the external review rules in favor of the patient and the care, then the fine of $1,000 a day takes place until they do comply, and there is no cap. It also enables the patient to go to any health care provider that they see fit at that time and be treated. Is that not far better than waiting and going to court and maybe 3 years down the road you get a verdict in your favor. In the meantime, what are you doing about the care that you need in order maybe to live? It is good for your heirs, but it is not very good for you.

If people say, well, there will not be many lawsuits, read last week's Wall Street Journal. The same plaintiff lawyers who took on the tobacco companies and are taking on the gun manufacturers are lining up for the biggest pot since tobacco, the HMOs. And when they sue, they will not just sue the HMO, they will sue everybody in sight, including the employer. And employers, many of them, are not going to put up with that. What they will do will be to put the money in the worker's envelope and say, you are on your own. Unfortunately, many of them, you know how young people are, they think they are eternal, they will not buy insurance. They would rather have an automobile or something else, or take a trip, and that $44 million uninsured number will go up dramatically.

We increased our uninsured last year by 1 million at a time when we have virtual full employment. So, we need to pass the Boehner bill to make sure that patients get care and not courts.

Mr. Chairman, I rise today in strong support of the Boehner substitute to H.R. 2723.

Managed care is an essential component of our health care delivery system today. The notion of managing care grew out of a concern over a decade ago that health care costs were escalating, and something needed to be done to get control over these skyrocketing annual cost increases. In response to these concerns, insurers began to contract with health care providers to arrange to have a broad network of health professionals available to provide benefits. Health professionals accept reduced fees in exchange for access to a high volume of patients; and plan enrollees pay lower premiums in exchange for seeing one of the health professionals in the network. In addition, plans have quality assurance and utilization review programs to ensure that patients continue to receive cost-efficient quality health care.

This private sector response to the increase in health care spending in the 1980's succeeded in reigning in health care spending, while maintaining and yes, even improving the quality of care for millions of Americans. Many health care professionals believe that the techniques used by managed care companies, such as promoting wellness, the strong emphasis on preventive care, and the ability to ''manage one's care,'' have been valuable contributions to improving the health of America.

The pendulum which started on the side of high health costs, with no control on utilization, has swung towards lower costs and increased scrutiny of the types of services health professionals are performing. We are here today, to decide how far that pendulum has swung. I agree that many of the provisions in all of the bills we are discussing today are reasonable—ensuring that doctors are not limited in the treatment options they can share with their patients; guaranteeing women direct access to their OB/GYN provider, and ensuring that children can have their pediatrician serve as their primary care provider, are just some of the common sense protections that I think we all support.

I also support providing as much information as possible that the patient would find useful in evaluating their health care options. That is why I submitted an amendment which would have required physicians to disclose malpractice judgments or criminal convictions issued against them. If this amendment were law today, a consumer would be able to use the Internet to thoroughly research the background of any physician licensed to practice medicine in the United States. I was disappointed when this amendment was not made in order.

There are two provisions in the Boehner substitute that I would like to bring to everyone's attention, because I feel they are positive steps towards ensuring quality without compromising on accountability. The first is

the responsible and common sense way in which a plan is held accountable once an independent medical expert has determined what the course of treatment for a patient should be. If the plan does not arrange to provide the care in accordance with what an independent medical expert has determined to be appropriate care, the plan will be fined $1,000 per day until the plan complies with the independent expert's opinion. More importantly for the patient, he or she can see any provider at any facility he or she chooses, and the plan has to pay for it. This is a commonsense approach towards ensuring the patient gets the care he or she has paid for, and holds the plan accountable for providing that care in a timely manner. Care, not courts—that is what patients want when they seek medical attention.

The second provision I would like to mention, which prior to this year had been strongly supported by the AMA, is medical malpractice reform. The Boehner substitute would reform the guidelines governing health care lawsuits by, among other things, limiting ''non-economic damages to $250,000, but deferring to states if they feel a higher or lower amount is appropriate. Health care expenditures should be directed towards improving the health of America's patients; not towards lining the pockets of trial lawyers—too often the case today. These reforms would keep more dollars going to patient care and less to the trial lawyers.

I am extremely concerned about the terms of the debate we are having today. One million Americans lost their health insurance coverage in just this past year alone. That is the crisis in health care in America today. If we legislators want to alter the way in which health care is delivered through private markets in this country, we owe it to the American people, to those who sent us here to do the people's work, to at a minimum, abide by the Hippocratic oath that health professionals are obligated to follow every day, which states ''First, Do No Harm.''

I am disappointed that the debate has focused more on trial lawyers, than on how we can create incentives for the private insurance market to offer more affordable health insurance for all Americans.

Those favoring increasing the role of trial lawyers in our health care delivery system point to Texas as an example of what happens when a state allowed state court action against a health plan, and yet only a handful of suits have been filed. This does not tell the whole picture. Just this week in an article printed in the New York Times by Dave Morehead, a doctor with the Scott and White Health Plan in Texas, Dr. Morehead states, ''Lawsuits cost companies money, but so does the mere threat of a lawsuits.'' He points out that as a result of the recent legislation passed in Texas, the physicians participating in the Scott and White Health Plan have changed the way they practice medicine. Preauthorization requirements which are utilized as a means to ensure that patients receive a course of treatment that is safe and effective, thus reducing the risk of complications which often result from some procedures, have been discontinued for fear of litigation resulting from any delay in treatment. He adds that 25 to 35 percent of tests and treatments do not contribute to better health. Dr. Morehead sums up his experience in Texas by concluding 'Our experience shows that the right to sue doesn't help patients get better care. It just drives costs up, for us and for them.''

How many times do we have to come to the well this session on a highly politicized issue and find the trial lawyers actively campaigning for more litigation. First it was tobacco, then guns, now health care. If lawyers are going to start getting in the business of practicing medicine, perhaps we should require them to go to medical school. I am sure the physician community would welcome them, as ironically they too are advocating for more lawyer involvement in the delivery of health care in this country today. On the other hand, this might give the public more comfort. Since lawyers and judges will be making clinical decisions as a result of some of these bills, perhaps we should require them to at least have some medical training.

America has the greatest health care in the world. The fact that 16.3 percent of our fellow citizens cannot afford it is deeply troubling. That the plight of these 44.3 million Americans has been lost on helping the trial attorneys is tragic. I hope members will think of the 44.3 million of Americans who do not have any health insurance as they consider what legislation to vote for today. Do patients deserve care or courts? I vote for care and that is why I am supporting the Boehner substitute, and encourage my colleagues to do the same.

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

Mr. GANSKE. Mr. Chairman, a fundamental flaw, a fundamental flaw in the bill that passed the Senate and in the Boehner bill is that it does not address the issue of medical necessity. The problem in the ERISA plan, and that is under ERISA law, a health plan can define medical necessity in any way they want to. The gentleman's bill does nothing to change that, he would agree with me on that.

Let me cite an example of why that could be a problem. Let us say that a health plan sets up its definition for getting psychiatric care, saying that somebody has to try to commit suicide three times before one can qualify. That may sound absurd, but let us just say that the plan does that.

A little boy goes out, a teenager, tries to commit suicide once, tries to commit suicide twice, and finally on the third time, commits suicide. Now, under the Boehner bill, that plan followed its own criteria. Guess what? Under the Boehner bill and under the bill that passed the Senate, there is no recourse, because ERISA says that the health plan can define medical necessity in any way they want to, no matter how unreasonable the criteria are or seem to be by an independent panel, review panel. They still, under ERISA law, cannot change the fact that a health plan could define medical necessity as the cheapest, least expensive care.

We could take a little boy with a cleft palate, a health plan could say all we are going to provide treatment for that is a plastic obturator, a piece of plastic stuck up into that hole. If that is the way the plan's employer has defined medical necessity, there is no recourse, even if it does not fit any prescribed standards of care.

That is such a fundamental problem that is not addressed in the Boehner bill and that was not addressed in the Senate bill, and on that alone we should vote no on the Boehner bill.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I rise in opposition to the Boehner substitute.

The key questions here are who decides who gets care and on what basis. The Boehner substitute says the managed care plan decides who gets care on any basis they find economically viable.

When a Member of our family, when someone we love has to see an oncologist or a cardiologist or a speech therapist, the reason we are here today is that too many people have been told no, that that is not something that is appropriate under their plan. The underlying Norwood-Dingell bill says that decisions about who will get that care will be made by qualified, independent medical professionals. The Boehner bill says the plan will decide, and when the plan decides on the basis of its own economic motivation, its own definition of what is best for the plan, no one is held accountable.

The Boehner substitute fails the two most critical tests that are before us today in protecting the rights of patients. When it comes to the issue of whether decision-makers are held accountable, the Boehner substitute says, they are not held accountable in the same way that delicatessens and fast food restaurants and homebuilders and everyone else in America is held accountable.

When it comes to the issue of the standard on that decision, the Boehner bill says the plan sets the standard. We say the medical professionals acting in consultation with the families should set that standard.

Reject the Boehner substitute; stand for the Norwood-Dingell bill.

Mr. BOEHNER. Mr. Chairman, I yield 2½ minutes to the gentleman from Missouri (Mr. TALENT), the chairman of the Committee on Small Business.

Mr. TALENT. Mr. Chairman, we have a problem in America with health care today. We addressed one of the problems yesterday, trying to help the uninsured.

The other problem is people who have insurance and cannot be certain that they will get the coverage they have been promised when they get sick. So their insurance is fine, and then when they get sick, they are concerned that their HMO may turn them down for coverage, and they have a right to be concerned, and we need to address that, and the Boehner bill does that.

The idea is to provide people with the care that they need when their physician prescribes it before they become seriously ill or die. The key to that is the external review process that is in this bill, and what it says, quite simply, is this: your physician, let us say, prescribes for you a cardiac cath. The plan turns it down and says no, you only need beta blockers. You can appeal immediately to an independent panel of specialists, cardiologists in that field who are fully vested with the authority to reverse the HMO's decision. They have to take into account all of the evidence that is given, including the protocols that the plan wants to follow, but they are vested under this bill with the authority to reverse the decision of the HMO. I read that language this morning.

It is frustrating how we all seem to agree we want the same thing here, and then we are arguing about what the bills actually say. The bill vests the authority in the independent reviewers to reverse decisions of the plan with regard to medical necessity.

Now, why is that better than open-ended liability against employers and plans as is provided in Norwood-Dingell? Because that will take billions and billions of dollars out of treatment rooms and put it into courtrooms. That will take billions and billions of dollars out of care and put it into legal fees and defensive medicine and everything that we have been struggling with for years and years and years with regard to providers and physicians.

□ 1130

Mr. Chairman, it does not have to be all or nothing at all. It does not have to be the world we have now where the plans are unrestricted, where you cannot control what they do, or where we open this thing up to lawsuits against every employer in the country who has a group health plan and all the plans in unrestricted fashions. We can have a good, measured response that makes sure people get the care they need when their physician prescribes it without big government, without thousands and thousands of lawsuits that will draw money out of treatment rooms and put it in the courtrooms. I think the gentleman has a good idea. I am going to support his bill.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Chairman, children are not just little adults. They have different health and developmental needs than adults, and they often require age-appropriate pediatric expertise to understand, diagnose, and treat their health problems. They deserve health care providers that have training and expertise in their conditions. H.R. 2723, the Dingell-Norwood bill, contains provisions that allow children to have access to pediatricians, access to pediatric specialty care, access to emergency care, continuity of care, appeals to pediatric experts, and pediatric quality assurance provisions.

The Boehner substitute, however, as we can see from this chart, fails to measure up in every single comparison. Children are far too often put at risk by being inappropriately referred to certain adult specialists who are not trained in children's health needs. Who is affected? Children like Kaitlynn Bogan of West Alexandria, Ohio, whose health plan would not refer her to a pediatric gastrologist and who continued to react with blood curdling screams until the Bogan family mortgaged their home and went outside the plan to a pediatric specialist who corrected her problem.

Carley Christie of Palo Alto, California, who was inappropriately referred to an adult specialist for a Wilms' tumor who performed a needle biopsy which punctured the tumor and essentially tripled the duration of Christie's chemotherapy. The family, finally on their own and at their own expense, again elected to have the surgery performed by a qualified pediatric specialist.

Mr. Chairman, the American public strongly supports allowing families like these to get access to the critical pediatric care they need. In fact, 86 percent of Americans have expressed their support for the Dingell-Norwood plan that would ensure children get access to pediatric specialists like pediatric heart specialists and surgeons and to hospitals that specialize in treating children. As adults, we have a responsibility to our kids. I urge my colleagues to reject this amendment and to support the Dingell-Norwood plan.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the gentleman from Utah (Mr. COOK).

Mr. COOK. Mr. Chairman, I rise in support of the bipartisan patient protection plan offered by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL). I want to commend the leadership of the House for allowing what I think has been a very fair and an open debate. Quality health care is one of the most important issues facing our constituents.

Now, each of these proposals, all of the bills that are being debated today, have some very good ideas in them. However, I have concluded that the Norwood-Dingell approach is the best. If Americans have the right to sue for a damaged fence or an unsafe toy, they should have the right to sue if their health or life has been endangered or lost. This is a constitutional right.

Doctors already face liability. But too often their decisions are forced upon them by an insurance plan. It is only fair, it is only American that the insurance plans be held to the same accountability. The State is the appropriate venue for these cases. States already license the doctors. They license the health plans. And we all know that the Federal courts are already overwhelmed with criminal cases.

I cannot understand why those of us that believe in the importance of States rights are so eager to try to throw some of these cases into the Federal system. The doctor-patient relationship has been damaged in this country, and I believe that the Norwood-Dingell bill is going to help restore that relationship and hopefully will put doctors and patients back in control of what I think ought to be a private health care system.

Mr. BOEHNER. Mr. Chairman, I am happy to yield 2½ minutes to the gentleman from North Carolina (Mr. BALLENGER), chairman of the Subcommittee on Workforce Protections of the Committee on Education and the Workforce.

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

Mr. BALLENGER. Mr. Chairman, first of all I thank the gentleman for yielding me this time. I think it is important to realize what small businesses will do when they are faced with health care liability provided by the Norwood-Dingell bill.

Let me show Members what increased liability will do to my own small company in North Carolina. We have 200 employees. We self-insure. Our health insurance expenses last year were a total of $700,000. Of this cost, the company voluntarily paid $550,000, or $2,750 per employee. For additional coverage, the employees collectively paid $150,000, or $750 per employee. Now, the $2,750 per employee expense covered by my company is a voluntary fringe benefit.

Why would any company voluntarily give a fringe benefit that would expose them to the possibility of being sued? We can say that litigation is not likely but small business owners cannot afford to take that chance. With the specter of liability looming, it would make good business sense to give the employee a pay increase of $1.375 per hour, that is $2,750 spread over a year, give them $1.375 and advise each of them to get their own health insurance. This would leave my company free of liability. I guarantee that it would cost each employee substantially more to purchase insurance individually, and many employees would not use their wage increases for health insurance.

As Members can see, the liability provisions of Norwood-Dingell will lead to a greater number of uninsured nationwide. Unlike the liability-ridden Norwood-Dingell bill, the Boehner substitute will ensure patients' rights without exposing employers to lawsuits for voluntarily providing health care to their employees. A strong, binding, independent external review process for health plans, with a fine of $5,000 a day for plans who refuse to adhere to the decision of the panel of doctors, will provide accountability to the millions of Americans in employer-based care.

Do not jeopardize the employer-based health care system. Let the small businesses and employers continue to provide health care benefits to the American workforce. I urge my colleagues to vote for the Boehner substitute and the 150 million people who have insurance coverage right now.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Michigan (Ms. STABENOW).

(Ms. STABENOW asked and was given permission to revise and extend her remarks.)

Ms. STABENOW. Mr. Chairman, I am very pleased to be a cosponsor of the Norwood-Dingell-Ganske legislation. I want to particularly thank the gentleman from Michigan (Mr. DINGELL) for his leadership in this area.

I rise to strongly oppose the Boehner substitute. I want to take just a moment to share the story of Jessica Luker. Jessica died 3 weeks ago. She had an emergency operation on May 11. Her family found out on May 12 that they had suddenly become part of an HMO as of May 1. The HMO would not cover the emergency surgery. They would not allow her to continue with her doctor of 14 years, her neurologist who had been caring for her and her disability. Jessica died while her family was fighting the HMO that would not allow her to get the kind of care that she needed.

It is not right in this country when a family that is struggling to care for their dying daughter also has to fight their insurance carrier. The Boehner substitute would do nothing to help Jessica's family or her situation. I urge a ''no'' vote on the Boehner substitute and a ''yes'' vote on a real patients' bill of rights.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from New York (Mr. FORBES).

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

Mr. FORBES. I thank the gentleman for yielding me the time.

Mr. Chairman, I rise today and ask that we pass a comprehensive patients' bill of rights and reject the Boehner and other substitutes that would only delay what this Nation needs. It needs accountability with our HMOs; we need consumer protections; and we need to put the doctors and health care professionals back in charge.

I am reminded of a family up in the north fork of Long Island, New York. Mae woke up in the middle of the night. Her husband was gagging and choking in blood. He was lying in a pool of blood. She did not call 911. Why? Because when she called it a month earlier, 911 arrived and when she got home from the hospital with her husband, the bills came in and they were not paid because a clerk said at the HMO that it was not deemed an emergency.

So this time she calls the 24-hour hotline for the HMO. They have the privately contracted ambulance come from somewhere up the island half an hour after her husband stopped breathing. The privately contracted ambulance arrives and, of course, unfortunately her husband was dead. These kinds of incidents require that we move as a Congress to get a comprehensive patients' bill of rights. I urge passage of Dingell-Norwood and rejection of all the substitutes.

Mr. BOEHNER. Mr. Chairman, I yield myself 15 seconds. The last 2 examples that were presented on the floor by the other side would be protected under the Boehner substitute today. The accountability procedures in our bill guarantee access to care. The only real difference between these two bills is that we do not allow lawsuits filed to drive employers into bankruptcy.

Mr. Chairman, I yield 2 minutes to the gentleman from Michigan (Mr. KNOLLENBERG).

Mr. KNOLLENBERG. Mr. Chairman, I thank the gentleman for yielding me this time. I rise in strong support of the substitute offered by the gentleman from Ohio.

Mr. Chairman, I urge my colleagues to remember the important principle behind the creation of the Employee Retirement Income Security Act of 1974, better known as ERISA. In response to a number of flagrant abuses to benefit plans, it was decided that protecting the interests of employers as well as the beneficiaries was of the utmost importance. Because of this sentiment, ERISA abides by the predominant view that employees should be afforded the opportunity to quality care.

These provisions apply to nearly 150 million employees, 80 percent of our Nation's workers, who otherwise may not have obtained the necessary access to the vital coverage that they require. Because plans would be subject to the same benefit laws across the States, costs are kept down because government regulations which traditionally drive costs up are eliminated.

Look at the numbers. We have heard them before. Some 44 million Americans do not have health insurance. That means one out of six do not have health coverage. The other proposals that we are considering today, that we have been listening to, would significantly raise premiums, some by over 4 percent. The nonpartisan CBO, Congressional Budget Office, concludes every percentage point in premiums that are increased translates into 400,000 people losing their coverage.

Common sense tells us that what we should be doing is to consider ways to provide coverage for all Americans, not forcing people out of their health coverage. Make no mistake about it, the chief beneficiaries of preempting ERISA would be the trial attorneys. Consumers and employers would be left to pick up the bill for increased and often frivolous litigation.

This Congress must ensure the patient's right to care, not the lawyer's right to bill. The alternatives offered today do nothing to help sick people get better. That is what this debate should be about. That is why I support the Boehner substitute, and I believe all Members should.

Mr. BROWN of Ohio. Mr. Chairman, I ask unanimous consent to claim the time of the gentleman from Michigan (Mr. DINGELL).

The CHAIRMAN. Without objection, the gentleman from Ohio will control the time in opposition.

There was no objection.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentleman from Georgia (Mr. NORWOOD), the sponsor of the underlying Norwood-Dingell bill.

Mr. NORWOOD. Mr. Chairman, I think it would be sort of nice and fun if I took a minute and responded to my good friend the gentleman from North Carolina (Mr. BALLENGER). He said that he is a business owner, a small business owner, and he does not want his business sued, he does not want to be sued. I could not agree with that more. Of course we do not want to do that. That is why we really do not do that. The gentleman from North Carolina has discretionary authority over his small company. He is the CEO, he is the owner, he is the President.

□ 1145

But he is also the congressman. He is in Washington. He is not making medical necessity decisions for his employees at all. It is that third-party administrator that he hired to decide whether those patients get to be hospitalized or whether they get that surgery or whether they get that operation. That is who we are talking about. That is who we are putting under the gun, that third-party administrator.

Our bill says over and over again, it protects the gentleman from North Carolina, but it does go after that third-party administrator in a very tailored way. All it says, one thing, if one denies a benefit that is a benefit in the plan, that was a benefit the gentleman from North Carolina thought his people ought to have, and one denies it arbitrarily, and one kills somebody, one has to be responsible for those decisions.

What are they going to do? They are going to carry malpractice insurance like the rest of the world has to. What is that going to cost? Fifteen to 20 cents a month per patient. But it gives those people that are patients, that work for the gentleman from North Carolina the feeling, the encouragement they actually will have decisions made by their doctors, not by that clerk that may be living in Missouri. That is what it is all about.

I have told the gentleman from North Carolina over and over again, we are not going to sue him. We do not want to sue him. We do not want to sue small businesses. That is why we wrote the bill. Page 99, look at it. We protect the gentleman from North Carolina. But his third-party administrator must be careful.

Mr. BOEHNER. Mr. Chairman, I yield myself 1 minute.

Now, the gentleman from Georgia (Mr. NORWOOD), my dear friend who believes passionately on this issue, and I congratulate him for the 5 years he spent moving this issue along, but we have a very serious disagreement here, because not only are my colleagues exposing health plans and employers to liability, they are jeopardizing the health coverage for millions of Americans because, in the end, it is the health plan and the employer that is going to pay the bill.

Now, under our system today, the employers provide coverage for 125 million people. If my colleagues raise the cost to them and expose them to liability, guess who is in danger? Their employees are. That is not what we want to do.

Now, the gentleman says, well, employers are shielded. The fact is, under ERISA, employers have to provide a fiduciary responsibility. They have to use discretion on behalf and for the benefit of every employee in the plan. We cannot create a wall that says we are going to punish health plans without hurting employers and their employees.

Mr. Chairman, I am happy to yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Chairman, I wish to speak in favor of the Boehner amendment today. I believe that this amendment achieves the necessary balance between protection of individuals enrolled in managed care plans and keeping their care affordable and accessible for employers and their employees.

The last thing we want to do is drive up the number of uninsured Americans today. Too many costly mandates and too many costly lawsuits will result in just that.

I firmly believe that real patient protections are ensuring greater access to care, more affordable care, and the highest quality care. According to the Census Bureau, we have 44 million Americans who are uninsured today. The last thing we want to do is drive that number up. We want to get that number down, not up.

We must approach managed care legislation in the same way we approach other mandates we have voted on. We need to consider its effect on the individuals in this country and on their ability to access quality health care.

I have heard from hundreds of employers and their representatives from my district, the First District of Wisconsin, who are extremely nervous about this action that we are taking here today. They are nervous, not because they may be required to provide more benefits, that is a fine thing, but they are nervous because they may be facing a whole new array of lawsuits simply because they choose to offer health care for their employees.

I urge Congress to consider those businesses and the people they employ in this debate today. Anything we do to drive up their costs to expose them to a whole new feeding frenzy of lawsuits will drive up the number of uninsured.

We must strive to protect the rights of individuals in managed care, make sure that they are not wrongfully denied care, but make sure that health care remains affordable and accessible.

The Boehner amendment strikes that balance. It contains strong measures to review health care decisions. It requires an internal review, external review that has teeth and enforcement measures. More importantly, we need to make sure that the relationship in health care is between patients and their doctors, not patients and the HMOs and patients and their trial lawyers.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Wisconsin (Mr. KIND).

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

Mr. KIND. Mr. Chairman, I thank the gentleman from Ohio for yielding me this time.

Mr. Chairman, I rise today as a supporter of Norwood-Dingell and in strong opposition to the Boehner substitute.

This debate is really a very simple debate. Do my colleagues think that medically necessary, important health care decisions should be placed in the hands of doctors in consultation with their patients or should health plan administrators sitting in their offices hundreds of miles away be making these life-and-death decisions. And there are life and death decisions being made.

For me, the debate is about a young family in western Wisconsin who, 2 years ago, were informed that their 10-year-old little girl had an inoperable brain tumor, and they wanted this particular form of treatment that the doctor was recommending.

The health plan administrator says, ''We will cover that as long as it is an AMA-approved treatment.'' The problem, when they talked to the AMA, is that there was no such thing as an ''AMA-approved'' treatment. So they denied coverage.

As a father of 2 young boys myself, I can think of no greater fear than a parent facing the prospect of losing a child.

They then did what any parents would do under the circumstances. They went into debt. They borrowed. They took a second mortgage out in order to finance the treatment. They ended up with over $100,000 of debt. That young girl eventually died last year. It should not be this way.

Under the Norwood-Dingell bill, administration of a health plan will no longer be able to hide behind the shield of ERISA protection but instead will be subject to an internal and external review process and held responsible for negligent medical decisions.

No longer should parents be faced with the draconian decision of having to mortgage their families' life away or face the prospect of losing a child. Let's put medical decisions back in the hands of doctors and their patients, not insurance companies.

I urge my colleagues to support the Norwood-Dingell bill and oppose the Boehner and other substitutes.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Chairman, do my colleagues realize that the only people in our society that are exempted from our laws and exempted from being sued are foreign diplomats and HMO bureaucrats? They are the only ones in our society that are held above the law.

My colleagues read about where that foreign diplomat ran over that young girl in Washington, D.C., never had to be held liable until the Georgian government said that he had to be held liable. Guess what? The same blanket immunity that those foreign diplomats have these HMO bureaucrats have.

Now, the thing that is going on here is these HMO bureaucrats forget medical malpractice. That is when a doctor makes a bad decision. We are having people who have no medical education whatsoever, never went to medical school, they are the ones making medical decisions. That is criminal.

If my colleagues think medical malpractice is criminal, try having someone who has no medical experience whatsoever making a medical decision. That is criminal. Those two instances, this Boehner bill will not cover; and that is why we ought to reject the Boehner substitute.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Louisiana (Mr. JEFFERSON).

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

Mr. JEFFERSON. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, who would have ever thought just a few short years ago that we would earnestly debate here in this Congress whether a child needing medical attention could see a pediatrician or whether a woman could engage an OB/GYN for her primary care or whether a cancer patient could follow the advice of a family physician and see a cancer specialist?

It seems obvious that people should be able to make these choices for themselves and for their families. What is more odd is that the choices and the access, which we seek today through the passage of the Dingell-Norwood Patients' Bills of Rights, are choices that our people used to have.

In this sense, Dingell-Norwood is not declarative of new rights for patients, but is restorative of old ones.

But the trouble with restoring old choices, the other side says, is the new costs involved that make health care choices unaffordable.

But are we to assume that every level of every profit center in every

HMO plan is reasonable, that every expense incurred by every HMO plan is warranted, or that greater patient choice will not usher in greater competition among HMO plans that will work to drive plan costs down? I think not. Besides, this has not been the experience of States which have undertaken HMO reform.

The three amendments offered by my Republican colleagues make these vital decisions for consumers. I urge Members to reject the tempered approach of the Boehner-Coburn amendments and embrace the bold approach of Dingell-Norwood.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania (Mr. HOEFFEL).

Mr. HOEFFEL. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I rise in opposition to the Boehner amendment and in strong support of the Norwood-Dingell underlying legislation. The gentleman from Iowa (Mr. GANSKE) got it entirely correct when he identified, as others have, that the key here is the question of medical necessity.

The Boehner substitute would continue to allow insurance company bureaucrats to determine what is medically necessary. That has got to stop. We must allow medical doctors once again to make the decisions that affect the quality of their patients' care. We must allow them to determine medical necessity, not the insurance bureaucrats.

Like our doctors who have complained to me in huge numbers, the Montgomery County, Pennsylvania Medical Society to a person tells me that they spend far too much time fighting with insurance companies, and that is time taken away from patient care.

Let us oppose the Boehner substitute and pass Norwood-Dingell.

Mr. Chairman, I rise in opposition to the Boehner substitute and in support of the base bill, the Bipartisan Consensus Managed Care Improvement Act.

I am a cosponsor of H.R. 2723 because it would allow Americans to be treated as patients, not as numbers that affect the bottom line.

HMO encroachments on the quality of health care are real.

One of my constituents, Dr. Peter Lantos of Erdenheim, PA, described to me that when he needed prostate surgery, his HMO was unwilling to provide a list of specialists, making it difficult to make an intelligent choice. He was told to go to a specific hospital, not the one he preferred.

After fighting many layers of bureaucracy, Dr. Lantos prevailed. However, he lost what could have been critical time, although as a doctor he knew how to fight the system. What about the average person who does not? They would have lost even more valuable time.

H.R. 2723 would: strengthen doctor and patient control over medical decisions by allowing doctors, rather than accountants, to define "medical necessity"; protect patients by guaranteeing access to specialists, out-of-network doctors, out-of-network emergency rooms, and non-formulary drugs. It also increases choice by guaranteeing patients a point-of service plan option; prohibit gag rules on doctors, so they may discuss all treatment options with their patients; and hold HMO's accountable by establishing an external review process and allowing liability suits in state courts.

The Boehner substitute does not correct medical necessity, does not hold health plans liable, and waters down patient protections. It is not serious reform.

We spend millions of dollars training our doctors, and billions developing drugs, treatments and equipment to treat America's patients. Then we turn all of that knowledge and innovation and investment over to a bean counter from a business school. Something is wrong.

The most important part of a good bedside manner used to be the infusion of hope that everything would be done to fix what ails the patient. That has been replaced by a glance at the HMO manual and a shrug of the shoulder.

Doctors now take time they could spend with patients to argue with insurance companies.

America's patients deserve medical care that will make them well quicker and keep them well longer. They need more than a placebo, but sadly, that is all this bill is.

I urge my colleagues not to be fooled by this or the other two poison pill substitutes. Let's have a clean vote on Dingell-Norwood, clean up the Senate bill in conference, and send managed care reform to the American people before the holidays.

Mr. BOEHNER. Mr. Chairman, I yield myself 15 seconds.

Mr. Chairman, under our proposal, an internal review is required, as we have under existing law. Only a doctor can deny care at the internal review level. Then if it is denied, a patient has the ability to go to an external review where an independent medical doctor will determine whether, in fact, that care can be given.

Mr. Chairman, I am happy to yield 3 minutes to the gentlewoman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Chairman, as we debate this substitute, I am reminded of what Kentucky did in the General Assembly in 1994. They passed a bill much like the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) have proposed in this session and the last session of Congress, one that is highly regulatory, one that they convinced the public will give them more medicine at a lower cost. Of course none of this happened.

In fact, the highly regulatory procedures that were enacted by the Kentucky General Assembly is pointed to by every other one of the other 49 States as the disaster that anybody with any understanding of insurance and the cost of medicine would have understood.

The fact is 45 insurance companies out of 47 have left Kentucky. There are only two that are selling insurance in Kentucky today. The fact is the prices have skyrocketed. Just this year, businesses are telling me again of their increases at 38 percent and 50 percent.

We have an increasing number of workers today that are choosing not to take their company's health insurance because even their share of the premium at 10 or 25 percent is more than they want to pay.

Who is deciding not to take insurance? It is the healthy young workers, the workers we need in the health insurance system. Because insurance in all cases is one of those products where all of the people pay in, the healthy pay in, so that the people that get sick, that the costs are taken care of. When we begin to have the healthy young workers not buy insurance, what it does is create this spiral that continues. Health insurance goes up and up, outpricing most people that want health insurance.

It is terribly counterproductive for us to siphon off medical money, medical money that comes to the medical community from insurance and use it for legal services. We need to create a system where every dollar of medical money, money gotten through medical insurance, is spent on medical services and medical miracles.

We can do that if we ensure that insurance companies live up to their responsibility through an appeals process, appeals process within the plan, an appeals process outside of the plan, and not through siphoning off huge numbers of dollars and go back to the system of excessive medical tests that drove the costs so high originally by allowing lawsuits, more lawsuits than what we have now.

So I support the substitute of the gentleman from Ohio (Mr. BOEHNER), and I ask the rest of the Members to consider supporting it, too.

□ 1200

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentlewoman from California (Mrs. CAPPS), a member of the Subcommittee on Health and Environment.

Mrs. CAPPS. Mr. Chairman, I rise in strong opposition to the Boehner amendment. This substitute will not protect patients. This bill does not provide for independent and timely appeals when patients are harmed by HMO decisions. This amendment leaves in place what is wrong with the current system. HMO bureaucrats, not doctors, will determine what treatment is medically necessary. In comparison, the bipartisan Norwood-Dingell bill provides a core set of meaningful protections for patients. Finally, the Boehner amendment will not allow patients to sue their HMOs for negligent care.

The consensus bill includes a strong independent review panel procedure. And as a last resort, patients must have the ability to sue HMOs for harmful medical decisions. No other industry has such special legal protections. The HMO industry should not have them either.

I urge my colleagues to oppose the Boehner amendment.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Ohio (Mr. STRICKLAND), also a member of the Subcommittee on Health and Environment.

Mr. STRICKLAND. Mr. Chairman, I am angry today. I am angry because the constituents that I represent from southern Ohio are being denied their rightful medical care under today's system. I am angry because the health care insurance lobbyists are lining our walkways as we walk to this chamber. I am angry because hundreds of thousands of dollars have been poured into influencing the decisions of Members in this chamber in the last few days and weeks. I am angry because I believe Americans, moms and dads and children, are being injured and are losing their lives today because we have not had the courage to stand up and do the right thing for the American people.

I hope the American people are watching us today. I hope they take note of our votes today, because we have a forced choice. We can either support patients or we can support insurance companies. It is as simple as that. This substitute is a nonhelpful bill. We need to support the Norwood-Dingell bill and give the American citizens true protections in their health care coverage.

Mr. BROWN of Ohio. Mr. Chairman, I yield such time as she may consume to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

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

Mrs. CHRISTENSEN. Mr. Chairman, I rise in opposition to this amendment.

Mr. Chairman, I rise in opposition to the Boehner amendment, and ask my colleagues to vote against it. This is a poison pill amendment which would gut many of the provisions that are needed to implement true managed care reform.

The American people have told us time and time again, and in many ways, that they want the way that managed care delivers health care changed. They don't want it changed just for some, but for all. To half step change, as this amendment would do, would be more of a disservice than a service.

For example, Mr. Chairman, the Boehner substitute would half step the accountability provisions in the Dingell-Norwood bill by providing for an external appeal provision. The problem with this proposal and why it fall far short, is because the external reviewers in the Boehner substitute will use the HMO's plan definition of medical necessity and not the insured's physician.

If such a set-up could work there would be no need for the Norwood-Dingell.

It is precisely to get away from having the plan's definition of medical necessity be the determining factor and not the patient and his doctor's definition why we need the Norwood-Dingell bill.

Vote against the Boehner substitute and vote for a clean Norwood-Dingell bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 3 minutes to the gentleman from Michigan (Mr. BONIOR), the Democratic whip.

Mr. BONIOR. Mr. Chairman, I thank the gentleman for yielding me this time.

I recently met a woman from Marysville, Michigan. Her young daughter had only one kidney left and was in a fight for her life against diabetes. She desperately needed to see a specialist, but her HMO was worried about the cost, not getting this little girl the treatment that she needed. They were worried about how much it might affect their bottom line.

So what happened? They sent her to a general practitioner. That doctor could not help her. Her mother begged for a specialist. The HMO said, again, no, you have to go see somebody on the staff. So they sent her to another staff doctor. No answers. They still would not yield, the HMOs. This went on week after week after week. This girl got sicker and sicker and sicker, and ultimately the HMO refused to see her 10 different times before they sent her to a specialist. Ten times before a specialist.

She survived, but there are others who have not survived. This is what happens when insurance companies make medical decisions instead of doctors and patients. And that is why we are trying to come up with a bill today that will address this problem. Over 300 health organizations, the AMA, the cardiologists, Families USA, consumer and health groups have endorsed the Dingell-Norwood bill and are opposed to the Boehner substitute, which we are on now, the Shadegg-Coburn substitute, and the others that we will face.

They know that the insurance companies are out of control, these groups. Just look at the numbers. Eighty-three percent of the doctors surveyed say managed care has cut time that they spent with their patients. Eighty-six percent of the doctors say that managed care has reduced their access to specialists, in the example I gave previously. Almost 90 percent of the docs report that HMOs actually reject medical recommendations they make for their patients. And it goes on and on and on.

There is no accountability in the substitute that we are addressing here today. No recourse if an individual is turned down; nothing to give an individual the right to fight and to petition in a way that is going to hold the HMOs and the insurance companies accountable.

Vote against the substitute, vote against Coburn-Shadegg, vote against the substitute that follows that changes the course of direction in our courts, and vote for the bill that the American people are yearning for, waiting for, the bill authored by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL), as well as the gentleman from Iowa (Mr. GANSKE). It is the bill that will set us on the course to correct all of these abuses, all of these horror stories.

It is the doctors and the patients versus the insurance companies in this country. It could not be more clear.

Mr. BOEHNER. Mr. Chairman, I yield 1 minute to the gentleman from South Carolina (Mr. DEMINT).

Mr. DEMINT. Mr. Chairman, I rise in strong support of the Boehner substitute.

As an employer myself for 15 years, I am angry too that folks would stand up today and punish small employers as well as any size employers who try to provide health insurance for their employees.

I am angry at this idea that we can take health insurance out of the hands of employers and put it in the hands of the trial lawyers and expect to get better health care.

I am angry that yesterday I was in this room and this same group who is arguing for more liability today would try to keep individuals from owning their own health insurance so they could protect themselves by making their own health care decisions.

And I am angry today that now they are back making it harder for employers to buy that health insurance for individuals who cannot buy it for themselves.

I am angry because there is no one here suggesting where they are going to go when they cannot buy it for themselves, yet we do not want employers to buy it any more. Because the question is not whether people will have good health care, it is whether the health care system will be run by attorneys or will be run by physicians.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee (Mr. TANNER).

Mr. TANNER. Mr. Chairman, I thank the gentleman for yielding me this time, and I would like to engage in a colloquy with the gentleman from Michigan (Mr. DINGELL) and the gentleman from Georgia (Mr. NORWOOD) about the underlying intent of the bill.

Is it the intent of the sponsors to permit claims to be brought against independent insurance agents who work with employers in helping to select a plan?

Mr. DINGELL. Mr. Chairman, will the gentleman yield?

Mr. TANNER. I yield to the gentleman from Michigan.

Mr. DINGELL. The answer to the gentleman's question is no. If an independent insurance agent assists with the selection of or purchase of a plan, but is not involved in the medical care decisions, it is not our intent to permit a claim to be brought against the insurance agent, and under our proposal it cannot.

Mr. TANNER. Reclaiming my time, Mr. Chairman, I thank the gentleman.

It is an important clarifying position, and I wanted to make sure that the omission of specific legislative language in section 302 could not be interpreted to permit a claim against an independent insurance agent if that agent is not involved in the making of any actual medical care decisions.

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. TANNER. I yield to the gentleman from Georgia.

Mr. NORWOOD. I would say to the gentleman, Mr. Chairman, that I hope my son is watching this colloquy. He is an insurance agent.

But the gentleman is absolutely correct in his assumption.

Mr. DINGELL. Mr. Chairman, if an independent insurance agent assists with the selection or purchase of a plan but is not involved in the medical care decisions, it is not our intent to permit a claim to be brought against that insurance agent.

Independent insurance agents do not make medical decisions and therefore should not be liable for harm caused by a decision made by a group health plan. However, Section 302 dictates that claims may be brought against an employer or its employees, if the employer or employee participates in any way in the making of decisions on health care claims.

The omission of specific legislative language could not be interpreted to permit a claim against an independent insurance agent if the independent insurance agent is not involved in the making of any actual medical care decisions.

If this bill proceeds to conference, we would seek clarification that independent insurance agents are not to be held liable for medical and care decisions made by others. It is the intent of the legislation to limit liability only to those who make medical care decisions.

It is not our intent that independent insurance agents could be held liable.

Independent insurance agents who work with or on behalf of an employer in helping the employer to select a plan should be subject to the same liability parameters as the employer.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentlewoman from North Carolina (Mrs. CLAYTON).

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

Mr. Chairman, some would have us believe that this debate is about courts and lawyers. This is not about courts; it is about care. It is not about lawyers but about doctors having the right to provide that care.

I am against the Boehner substitute because it omits the needed enforcement of protection for patients and their doctors in providing that care. Similarly, I am against any substitution that caps damages, like the Coburn substitute. Likewise, I am against the Houghton-Graham substitute because it also strikes out the enforcement and compliance provided by the Norwood-Dingell bill on H.R. 2723.

When a person goes to the doctor, they are not interested in who they can sue. They are interested in who can cure them. But more importantly, Mr. Chairman, this debate is about care for all, rather than care for some. Some would have us believe that the tax package will result in all America's being covered and healthy. But such an approach to managed care reform will not result in greater coverage; it will only result in benefiting the wealthy, the healthy, or those who are financially well off.

This is a misguided concern, Mr. Chairman, because in North Carolina 28.6 percent of children under the age of 19, who are at or below 200 percent of the poverty level, are without health insurance. Rural communities are disproportionately without care. Some 44.3 million people are uninsured in 1998, despite a good economy. Last year 1.7 million more people were uninsured than the previous year in households making below $50,000.

Mr. Chairman, we should support the Norwood-Dingell bill. It is about care, it is about opportunity, it is about accountability.

Mr. BOEHNER. Mr. Chairman, I yield 1 minute to the gentlewoman from Ohio (Ms. PRYCE), an esteemed member of the Republican leadership in the House.

Ms. PRYCE of Ohio. Mr. Chairman, I thank my good friend from Ohio for yielding me this time, and I rise in support of the Boehner substitute.

Mr. Chairman, since his markup, the gentleman from Ohio has continued to work to improve upon his proposals. Specifically, he deserves credit as the first one to add strong cancer clinical trials language to his proposal. This language gives cancer patients access to all trials approved by the FDA or sponsored by federally approved entities, as well as those sanctioned by the Department of Defense, NIH, and Veterans Affairs.

We simply must increase participation in clinical trials if our researchers are going to make strides in their search for new treatments and a cure for this horrid disease. This language has the support of some 40 cancer organizations, and it is not in the Dingell-Norwood bill.

In addition to cancer patients, the Boehner substitute offers all patients basic protections. The amendment bans gag rules, ensures emergency room coverage, provides direct access to OB-GYNs and pediatricians, and offers continuity of care. These are the common sense reforms that we all agree on.

I encourage all of my colleagues to support the Boehner amendment.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentleman from Wisconsin (Mr. BARRETT), a member of the Subcommittee on Health and Environment.

Mr. BARRETT of Wisconsin. Mr. Chairman, we have heard a lot this morning about lawsuits, and I want to talk a little bit about the lawsuits in Texas, because Texas has a law similar to the law that we are trying to pass. There have been less than a handful, less than five. Three of them involved persons who were denied access to a cancer specialist; and, as a result, their health deteriorated dramatically over that time period.

The fourth one, the one that struck me the most, was an individual who was in the hospital and his physician said that this patient should not be sent home because of his severe depression. The HMO bureaucrat demanded that the patient be sent home. The patient went home, swallowed a bottle of antifreeze and killed himself because of the decision of the bureaucrat.

Mr. Chairman, this piece of legislation, or this amendment, would deny access to the courts for that individual. I think that that would be wrong. I think that that is a situation where, clearly, the medical decision was not made by the physician. The decision was made by the HMO. And in order for us to move that decision-making process back to the physician, we have to have access to the courts.

Mr. Chairman, this is not going to create a wave of lawsuits, but it is going to protect those individuals who are denied medical care.

Mr. BOEHNER. Mr. Chairman, I yield myself such time as I may consume to say that the example just given would never happen under the Boehner proposal, nor would it happen under the Dingell-Norwood proposal, and the gentleman well knows that.

Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. ARMEY), the majority leader.

Mr. ARMEY. Mr. Chairman, I thank the gentleman for yielding me this time.

Let me begin my remarks, Mr. Chairman, by pointing out that this is a serious business we are about today, and I am proud it is being taken as seriously as it is by this body.

I would also like to thank those Members of this body who yesterday cast a vote that provided some equity and opportunity not only to the 44 million Americans that are today doing without insurance, but to the millions of additional Americans who buy their own insurance.

□ 1215

It is about time that we remove barriers to insurability from these people and treated them fairly under the law. I am proud that we passed those provisions last night.

But with respect to the offers we see contested here, I want to tell my colleagues I am speaking on behalf of the Boehner bill precisely because the gentleman from Ohio (Mr. BOEHNER) in crafting this bill kept his eye on the ball. He asked himself the question, who is this about? And the answer was, wholly and without compromise, the well-being of the patient and the patient's family.

Mr. Chairman, we have all been there ourselves and we have certainly seen our constituents there. They have someone they love, maybe it is mom or dad, maybe it is their child, maybe it is their spouse, someone they love, relying on their insurance coverage and a sense of security they have drawn from that, at a moment of medical stress; and they are scared. They are terrified, Mr. Chairman, that dad is not getting the right care, that their baby is not getting the right procedures. They

have doubts. They have concerns. They have worries. And they are frantic with fear.

Mr. Chairman, not only does the patient but the patient's family deserves to have an answer now from medical professionals. Now I must know. If dad is not getting the right treatment, what can we do to change it?

The gentleman from Ohio (Mr. BOEHNER) responds to that. He says the patient's well-being and that peace of mind of the family comes before the doctors, comes before the trial lawyers, comes before the health care provider, comes before everything. And that is what he provides, an immediate, comprehensive, compelling review by medical professionals that says, we give the right necessary treatment and we give it now.

How could anybody turn away from that and say instead to that distressed mother or father or husband or daughter, no, we would rather give you our promise that 6 months from now or maybe a year we will get you on the docket and we will let the lawyers and the judges decide what should have been the care that that precious baby got 6 months or a year ago?

No, that is not good enough, Mr. Chairman. That is not a good enough answer for my children. It is not a good enough answer for the parents. We must do what the Boehner bill says we should do, give that family that answer now and get the care to the parents now. It is about health care. It is about danger. It is about a chance to get a good recovery with the right care and get it now.

Let the trial lawyers and, for that matter, let the doctors take their turn. But today let us all vote for Boehner and let us put patients and the patients' families ahead of everybody else as this bill does.

The CHAIRMAN. The Chair would remind the Members that the gentleman from Ohio (Mr. BOEHNER) on the majority side has 3¾ minutes remaining, and the gentleman from Ohio (Mr. BROWN) on the minority side has 3¾ minutes remaining and the right to close.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to my friend the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Chairman, let me read a letter from my constituents Gary and Marlene Rappaport from Orange, Connecticut.

As parents whose 25-year-old daughter Rebecca died after delay in receiving a bone marrow transplant because of repeated denials from her insurance provider, we are writing in strong support of the Norwood-Dingell bill. As Rebecca wrote in her journal dated March 28, 1997, ''I would like my family to continue my pursuit of litigation, suing for gross negligence resulting in severe physical damage, physical pain and inestimable emotional suffering. My medical record, history, and physicians support my case. Should an award be given in my absence, I would like a significant portion donated to cancer research.

Rebecca had a full life ahead of her. She did not get that chance. Her parents are left with an unimaginable heartache, the loss of a beloved daughter, and nowhere to turn to address wrongful denial.

Vote against the Boehner substitute. It fails to cover all privately insured Americans, does not provide for independent or timely appeals of decisions. It does not provide for access to specialty care. And most of all, it does not allow patients to hold their health plans accountable.

The only bill that does that today is Dingell-Norwood. Do it. Pass Dingell-Norwood. Do it for the Rappaports and do it for families like them who are in pain and who are begging for our help here on the floor of this House today.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, I am here once again to ask my colleagues to reject all of the substitute amendments that are now being considered and vote for a clean Norwood-Dingell-Ganske bill.

I realize that I have not been here very long. But in the almost 3 years that I have been in Congress, this bill, H.R. 2723, represents the best example of bipartisan cooperation that I have ever seen.

What makes this compromise so special is that it was done in direct response to the concerns that have been brought to us by the people we serve, not out of our political interests but in the interests of all Americans.

The Goss-Coburn-Shadegg substitute puts an unnecessary albatross on the back of our attempts to have real managed care reform. Its purpose could not be anything other than to fatally poison a good bill, making it eligible for a sure veto, thus killing any chance for the American people to get the relief they so desperately seek.

I ask my colleagues to stand with the American people and against the HMO industry. Vote ''no'' on the Goss-Coburn-Shadegg amendment.

Mr. BOEHNER. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, what this debate really comes down to, I think, is whether we are going to have accountability through litigation and lawyers or are we going to have accountability through doctors.

To ensure accountability in health care decisions, I think my proposal vests its power in independent doctors to make the right medical decisions.

I think the Dingell-Norwood proposal believes lawyers are the best authority when it comes to medical treatment. They believe that employers who voluntarily provide health care insurance to their employees ought to be subject to open-ended liability if someone believes they have been treated unfairly.

This reminds me of the incredible logic of trial attorneys suing doctors for malpractice when they attempted to render medical care to injured or ill individuals on an emergency basis. What happened? Doctors and other health care professionals began to stand by and did not apply their knowledge and skills to help fellow human beings for fear of being sued by some enterprising trial lawyer.

Across this country, States and local governments had to pass good samaritan laws in order to protect doctors and nurses from doing the right thing in the first place.

Well, let me assure my colleagues, if we move forward on court liability for employers, today's employers are going to become the doctors and nurses of the 1970s. They will stand by and no longer offer health insurance to their employees. Instead of having 44 million Americans with no health care coverage, we will have tens of millions added to that list.

Now, let us put in place a binding external appeal that will ensure that patients get their care when they need it. As the Washington Post stated earlier this week: ''Our first instinct would be to try the appeals system first and broaden access to the courts only if the appeals process turned out after a number of years to not work.''

My colleagues, we have an opportunity today to do something that is responsible, responsible for our health care system by bringing more accountability to managed care without driving up costs and without creating more uninsured. It is a delicate balance that we walk between bringing more accountability without driving up the cost and driving down access to our system. We have a great system in America where employers are provided health care for 125 million American lives in a shared arrangement in most cases.

Unfortunately, the Norwood-Dingell bill today, in my view, will jeopardize the health insurance benefits that millions of Americans get. Do we really want to take that big step off of this cliff without a parachute? Do we really want to take the chance that millions of Americans are going to lose their insurance because we want to open this up to litigation and entreat the trial bar to another new field that they can go out and operate in?

I do not think that is what the American people want us to do. They want us to take a responsible approach. They want us to take an approach that will ensure they get the care without driving up cost and without jeopardizing the number one benefit that they appreciate from their employers.

Vote for the Boehner proposal.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, this substitute undoes the good bipartisan work that the gentleman from Michigan (Mr. DINGELL), the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Iowa (Mr. GANSKE) did to craft this very positive strong legislation.

Similar legislation is working in Texas where insurance companies are

held accountable when they make medical decisions.

The Boehner substitute, however, is not a serious legislative effort. It does not hold insurance companies accountable when they make medical decisions that harm people. For all the discussion and all the talk, Mr. Chairman, about lawyers taking over the health care profession, the Boehner substitute would hand the lawyer, not the doctor, the power to decide whether a case needs a medical evaluation.

Mr. Chairman, the majority of Members support the Norwood-Dingell-Ganske bill. Vote ''no'' on the Boehner substitute.

Mr. CLAY. Mr. Chairman, the Boehner substitute fails to provide enrollees with what they want most from their health plan—accountability. Under the Boehner substitute, all court actions would be subject to caps on noneconomic and punitive damages of $250,000. The Boehner substitute does not ensure that employees are adequately redressed when they have been injured. Therefore, health plans still retain an incentive to deny claims in order to cut costs. Every other business is subject to liability when they make negligent decisions, why should health plans be any different?

The Boehner substitute creates a health care access affordability, and quality commission. This proposed commission would establish model guidelines, evaluate the cost impact of proposed mandates, comment on secretarial reports, and conduct additional reviews requested by Members of Congress. However, what this proposed commission really does is create a new Federal bureaucracy that duplicates many functions that are ongoing, both within the Department of Labor and other parts of the Federal Government.

The Boehner substitute also contains a ''conscience clause'' that significantly weakens the anti-gag protection. This clause allows plans to limit or deny any coverage that is inconsistent with its moral or religious convictions. This provision essentially allows plans to gag their providers from discussing any issues to which the plan is morally opposed. Plans would be able to devise new strategies to deny care, under the guise of moral opposition. This is why I support the Bipartisan Managed Care Improvement Act, H.R. 2723. It represents a reasonable, bipartisan compromise that protects patients. This is not the case with the substitute before us. I urge my colleagues to vote ''no'' on the Boehner substitute.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from Ohio (Mr. BOEHNER).

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. BOEHNER. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 145, noes 284, not voting 5, as follows:

[Roll No 487]

AYES—145

Aderholt
Archer
Armey
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bereuter
Biggert
Bilirakis
Bliley
Blunt
Boehner
Bonilla
Brady (TX)
Bryant
Burr
Callahan
Calvert
Camp
Cannon
Chabot
Chambliss
Coble
Collins
Cox
Crane
Cubin
Cunningham
Deal
DeLay
DeMint
Dickey
Doolittle
Dreier
Dunn
Ehlers
Ehrlich
Everett
Ewing
Fletcher
Fossella
Fowler
Gekas
Gibbons
Gillmor
Goode
Goodlatte
Goodling
Goss
Granger
Green (WI)
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hyde
Jenkins
Johnson, Sam
Jones (NC)
Kasich
Kingston
Knollenberg
Kolbe
LaHood
Latham
Lewis (KY)
Linder
Lucas (KY)
Lucas (OK)
Manzullo
McCrery
McInnis
McIntosh
McKeon
Mica
Miller (FL)
Miller, Gary
Myrick
Nethercutt
Ney
Northup
Nussle
Ose
Oxley
Packard
Paul
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Portman
Pryce (OH)
Radanovich
Ramstad
Regula
Riley
Rogers
Rohrabacher
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sensenbrenner
Sherwood
Shimkus
Shuster
Simpson
Smith (MI)
Smith (TX)
Stump
Sununu
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thune
Tiahrt
Toomey
Upton
Walden
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Young (AK)

NOES—284

Abercrombie
Ackerman
Allen
Andrews
Bachus
Baird
Baldacci
Baldwin
Barcia
Barr
Barrett (WI)
Bass
Bateman
Becerra
Bentsen
Berkley
Berman
Berry
Bilbray
Bishop
Blagojevich
Blumenauer
Boehlert
Bonior
Bono
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Burton
Buyer
Campbell
Canady
Capps
Capuano
Cardin
Carson
Castle
Chenoweth-Hage
Clay
Clayton
Clement
Clyburn
Coburn
Combest
Condit
Conyers
Cook
Cooksey
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
Davis (VA)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Duncan
Edwards
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Foley
Forbes
Ford
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gejdenson
Gephardt
Gilchrest
Gilman
Gonzalez
Gordon
Graham
Green (TX)
Greenwood
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Horn
Hoyer
Hunter
Hutchinson
Inslee
Isakson
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kelly
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kleczka
Klink
Kucinich
Kuykendall
LaFalce
Lampson
Lantos
Largent
LaTourette
Lazio
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McHugh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Porter
Price (NC)
Quinn
Rahall
Rangel
Reyes
Reynolds
Rivers
Rodriguez
Roemer
Rogan
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Saxton
Schaffer
Schakowsky
Scott
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Shows
Sisisky
Skeen
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stark
Stearns
Stenholm
Strickland
Stupak
Sweeney
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thornberry
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velázquez
Vento
Visclosky
Vitter
Walsh
Wamp
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wilson
Wise
Wolf
Woolsey
Wu
Wynn
Young (FL)

NOT VOTING—5

Johnson (CT)
Kaptur
Larson
Metcalf
Scarborough

□ 1246

Ms. RIVERS and Mr. KUYKENDALL changed their vote from ''aye'' to ''no.''

Mr. BARRETT of Nebraska changed his vote from ''no'' to ''aye.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. LARSON. Mr. Chairman, on rollcall No. 487, I was inadvertently detained. Had I been present, I would have voted ''no.''

The CHAIRMAN. It is now in order to consider amendment No. 2 printed in part B of House Report 106–366.

AMENDMENT NO. 2 IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. GOSS

Mr. GOSS. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 2 in the nature of a substitute offered by Mr. GOSS:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Quality and Choice Act of 1999''.

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

Sec. 1. Short title; table of contents.
TITLE I— AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT
Sec. 101. Application to group health plans and group health insurance coverage.
Sec. 102. Application to individual health insurance coverage.
Sec. 103. Improving managed care.
''TITLE XXVIII—IMPROVING MANAGED CARE
''Subtitle A—Grievance and Appeals
''Sec. 2801. Utilization review activities.
''Sec. 2802. Internal appeals procedures.
''Sec. 2803. External appeals procedures.
''Sec. 2804. Establishment of a grievance process.
''Subtitle B—Access to Care
''Sec. 2811. Consumer choice option.
''Sec. 2812. Choice of health care professional.
''Sec. 2813. Access to emergency care.
''Sec. 2814. Access to specialty care.
''Sec. 2815. Access to obstetrical and gynecological care.
''Sec. 2816. Access to pediatric care.
''Sec. 2817. Continuity of care.
''Sec. 2818. Network adequacy.
''Sec. 2819. Access to experimental or investigational prescription drugs.
''Sec. 2820. Coverage for individuals participating in approved cancer clinical trials.
''Subtitle C—Access to Information
''Sec. 2821. Patient access to information.
''Subtitle D—Protecting the Doctor-Patient Relationship
''Sec. 2831. Prohibition of interference with certain medical communications.
''Sec. 2832. Prohibition of discrimination against providers based on licensure.
''Sec. 2833. Prohibition against improper incentive arrangements.
''Sec. 2834. Payment of clean claims.
''Subtitle E—Definitions
''Sec. 2841. Definitions.
''Sec. 2842. Rule of construction.
''Sec. 2843. Exclusions.
''Sec. 2844. Coverage of limited scope plans.
''Sec. 2845. Regulations.
''Sec. 2846. Limitation on application of provisions relating to group health plans..
TITLE II—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
Sec. 201. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 202. Improving managed care.
''PART 8—IMPROVING MANAGED CARE
''SUBPART A—GRIEVANCE AND APPEALS
''Sec. 801. Utilization review activities.
''Sec. 802. Internal appeals procedures.
''Sec. 803. External appeals procedures.
''Sec. 804. Establishment of a grievance process.
''SUBPART B—ACCESS TO CARE
''Sec. 812. Choice of health care professional.
''Sec. 813. Access to emergency care.
''Sec. 814. Access to specialty care.
''Sec. 815. Access to obstetrical and gynecological care.
''Sec. 816. Access to pediatric care.
''Sec. 817. Continuity of care.
''Sec. 818. Network adequacy.
''Sec. 819. Access to experimental or investigational prescription drugs.
''Sec. 820. Coverage for individuals participating in approved cancer clinical trials.
''SUBPART C—ACCESS TO INFORMATION
''Sec. 821. Patient access to information.
''SUBPART D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
''Sec. 831. Prohibition of interference with certain medical communications.
''Sec. 832. Prohibition of discrimination against providers based on licensure.
''Sec. 833. Prohibition against improper incentive arrangements.
''Sec. 834. Payment of clean claims.
''SUBPART E—DEFINITIONS
''Sec. 841. Definitions.
''Sec. 842. Rule of construction.
''Sec. 843. Exclusions.
''Sec. 844. Coverage of limited scope plans.
''Sec. 845. Regulations.
Sec. 203. Availability of court remedies.
Sec. 204. Availability of binding arbitration.
TITLE III— AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986
Sec. 301. Application to group health plans under the Internal Revenue Code of 1986.
Sec. 302. Improving managed care.
''CHAPTER 101—IMPROVING MANAGED CARE
''SUBCHAPTER A—GRIEVANCE AND APPEALS.
''Sec. 9901. Utilization review activities.
''Sec. 9902. Internal appeals procedures.
''Sec. 9903. External appeals procedures.
''Sec. 9904. Establishment of a grievance process.
''SUBCHAPTER B—ACCESS TO CARE
''Sec. 9912. Choice of health care professional.
''Sec. 9913. Access to emergency care.
''Sec. 9914. Access to specialty care.
''Sec. 9915. Access to obstetrical and gynecological care.
''Sec. 9916. Access to pediatric care.
''Sec. 9917. Continuity of care.
''Sec. 9918. Network adequacy.
''Sec. 9919. Access to experimental or investigational prescription drugs.
''Sec. 9920. Coverage for individuals participating in approved cancer clinical trials.
''SUBCHAPTER C—ACCESS TO INFORMATION
''Sec. 9921. Patient access to information.
''SUBCHAPTER D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
''Sec. 9931. Prohibition of interference with certain medical communications.
''Sec. 9932. Prohibition of discrimination against providers based on licensure.
''Sec. 9933. Prohibition against improper incentive arrangements.
''Sec. 9934. Payment of clean claims.
''SUBCHAPTER E—DEFINITIONS
''Sec. 9941. Definitions.
''Sec. 9942. Exclusions.
''Sec. 9943. Coverage of limited scope plans.
''Sec. 9944. Regulations.
TITLE IV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION
Sec. 401. Effective dates.
Sec. 402. Coordination in implementation.
TITLE V—OTHER PROVISIONS
Subtitle A—Protection of Information
Sec. 501. Protection for certain information.
Subtitle B—Other Matters
Sec. 511. Health care paperwork simplification.

TITLE I— AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 101. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title XXVIII, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 (as in effect on the date of the enactment of the Health Care Quality and Choice Act of 1999) with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 102. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title XXVIII with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

SEC. 103. IMPROVING MANAGED CARE.

The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—IMPROVING MANAGED CARE

''Subtitle A—Grievance and Appeals

''SEC. 2801. UTILIZATION REVIEW ACTIVITIES.

''(a) COMPLIANCE WITH REQUIREMENTS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

''(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization

review program that meets the requirements of this section.

''(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms 'utilization review' and 'utilization review activities' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

''(b) WRITTEN POLICIES AND CRITERIA.—

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

''(2) USE OF WRITTEN CRITERIA.—

''(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate practicing physicians, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

''(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

''(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for periodic evaluation at reasonable intervals of the clinical appropriateness of a sample of denials of claims for benefits.

''(c) CONDUCT OF PROGRAM ACTIVITIES.—

''(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by appropriate physician specialists who shall be selected by the plan or issuer and who shall oversee review decisions.

''(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

''(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

''(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits. This subparagraph shall not preclude any capitation arrangements between plans and providers.

''(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

''(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

''(d) DEADLINE FOR DETERMINATIONS.—

''(1) PRIOR AUTHORIZATION SERVICES.—

''(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, no later than the deadline specified in subparagraph (B). The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided.

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

''(I) receives a request for a prior authorization,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 2 business days after notification,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of the request for prior authorization.

''(2) ONGOING CARE.—

''(A) CONCURRENT REVIEW.—

''(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed or electronic form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

''(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

''(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

''(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

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

''(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, POST-STABILIZATION CARE, AND EMERGENCY AMBULANCE SERVICES.—For waiver of prior authorization requirements in certain cases involving emergency services, maintenance care and post-stabilization care, and emergency ambulance services, see subsections (a)(1), (b), and (c)(1) of section 113, respectively.

''(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

''(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed or electronic form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

''(A) the reasons for the denial (including the clinical rationale);

''(B) instructions on how to initiate an appeal under section 102; and

''(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

''(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

''(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

''(1) CLAIM FOR BENEFITS.—The term 'claim for benefits' means any request for coverage (including authorization of coverage), or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

''(2) DENIAL OF CLAIM FOR BENEFITS.—The term 'denial' means, with respect to a claim for benefits, a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide or pay for benefits (including items and services) required to be provided or paid for under this title.

''SEC. 2802. INTERNAL APPEALS PROCEDURES.

''(a) RIGHT OF REVIEW.—

''(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

''(A) shall provide adequate notice in written or electronic form to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied ''(within the meaning of section 2801(f)(2)), setting forth the specific reasons

for such denial of claim for benefits and rights to any further review or appeal, written in layman's terms to be understood by the participant, beneficiary, or enrollee; and

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

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

''(b) INTERNAL REVIEW PROCESS.—

''(1) CONDUCT OF REVIEW.—

''(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual (who shall be a physician in a case involving medical judgment) who has been selected by the plan or issuer and who did not make the initial denial in the internally appealable decision, except that in the case of limited scope coverage (as defined in subparagraph (B)) an appropriate specialist shall review the decision.

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

''(2) TIME LIMITS FOR INTERNAL REVIEWS.—

''(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed or electronic form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided. The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

''(I) receives a request for internal review,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 48 hours after notification,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of request for review

''(c) EXPEDITED REVIEW PROCESS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

''(A) in which, as determined by the plan or issuer or as certified in writing by a treating physician, the application of the normal timeframe for making the determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such individual's ability to regain maximum function; or

''(B) described in section 2801(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

''(2) PROCESS.—Under such procedures—

''(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

''(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

''(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

''(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 48 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

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

''SEC. 2803. EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made (within a reasonable period not to exceed 365 days) either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent).

''(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'externally appealable decision' means a denial of claim for benefits (as defined in section 2801(f)(2)), if—

''(i) the item or service involved is covered under the plan or coverage,

''(ii) the amount involved exceeds $100, increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from such index for September 2000, and

''(iii) the requirements of subparagraph (B) are met with respect to such denial.

Such term also includes a failure to meet an applicable deadline for internal review under section 2802 or such standards as are established pursuant to section 2818.

''(B) REQUIREMENTS.—For purposes of subparagraph (A)(iii), the requirements of this subparagraph are met with respect to a denial of a claim for benefits if—

''(i) the denial is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or

''(ii) in such denial, the decision as to whether an item or service is covered involves a medical judgment.

''(C) EXCLUSIONS.—The term 'externally appealable decision' does not include—

''(i) specific exclusions or express limitations on the amount, duration, or scope of coverage; or

''(ii) a decision regarding eligibility for any benefits.

''(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 2802(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 2802, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

''(4) FILING FEE REQUIREMENT.—

''(A) IN GENERAL.—A plan or issuer may condition the use of an external appeal process upon payment in advance to the plan or issuer of a $25 filing fee.

''(B) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse the denial of a claim for benefits which is the subject of the appeal.

''(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

''(1) USE OF QUALIFIED EXTERNAL APPEAL ENTITY.—

''(A) IN GENERAL.—The external appeal process under this section of a plan or issuer shall be conducted between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)). Nothing in this subsection shall be construed as requiring that such procedures provide for the selection for any plan of more than one such entity.

''(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The Secretary shall implement procedures to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner.

''(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of this paragraph shall be consistent with the standards the Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. All costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be

construed as applying to the imposition of a filing fee under subsection (a)(4).

''(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the Secretary that include at least the following:

''(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination described in subparagraph (B) based on evidence described in subparagraphs (C) and (D).

''(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is appropriate for the medical condition of the patient involved (as determined by the entity) taking into account as of the time of the entity's determination the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraphs (C) and (D). If the entity determines the decision is appropriate for such condition, the entity shall affirm the decision and to the extent that the entity determines the decision is not appropriate for such condition, the entity shall reverse the decision. Nothing in this subparagraph shall be construed as providing for coverage of items or services not provided or covered by the plan or issuer.

''(C) REQUIRED CONSIDERATION OF CERTAIN MATTERS.—In making such determination, the external appeal entity shall consider, but not be bound by—

''(i) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms;

''(ii) the decision made by the plan or issuer upon internal review under section 2802 and any guidelines or standards used by the plan or issuer in reaching such decision; and

''(iii) the opinion of the individual's treating physician or health care professional.

The entity also shall consider any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed. The entity also shall consider the results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

''(D) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

''(i) The results of professional consensus conferences.

''(ii) Practice and treatment policies.

''(iii) Community standard of care.

''(iv) Generally accepted principles of professional medical practice consistent with the best practice of medicine.

''(v) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

''(vi) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

''(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—

''(i) IN GENERAL.—A qualified external appeal entity shall determine—

''(I) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

''(II) whether an externally appealable decision involves an expedited appeal;

''(III) for purposes of initiating an external review, whether the internal review process has been completed; and

''(IV) whether the item or services is covered under the plan or coverage.

''(ii) CONSTRUCTION.—Nothing in a determination by a qualified external appeal entity under this section shall be construed as authorizing, or providing for, coverage of items and services for which benefits are not provided under the plan or coverage.

''(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

''(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide to the external appeal entity timely access to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity. The provider involved shall provide to the external appeal entity timely access to information relevant to the matter of the externally appealable decision, as determined by the entity.

''(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

''(i) be made orally or in written or electronic form and, if it is made orally, shall be supplied to the parties in written or electronic form as soon as possible;

''(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 48 hours after the time) of requesting an external appeal of the decision;

''(iii) state, in layperson's language, the scientific rationale for such determination as well as the basis for such determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

''(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek binding arbitration or further review by the courts (or other process) of the external appeal determination.

''(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity determines that a denial of a claim for benefits was not reasonable and reverses the denial, the plan or issuer—

''(i) shall (upon the receipt of the determination) authorize the provision or payment for benefits in accordance with such determination;

''(ii) shall take such actions as may be necessary to provide or pay for benefits (including items or services) in a timely manner consistent with such determination; and

''(iii) shall submit information to the entity documenting compliance with the entity's determination and this subparagraph.

''(J) CONSTRUCTION.—Nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are not provided under the plan or coverage.

''(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified external appeal entity' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

''(A) The entity meets the independence requirements of paragraph (3).

''(B) The entity conducts external appeal activities through at least three clinical peers who are practicing physicians.

''(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

''(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

''(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to a group health plan or health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

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

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

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

''(i) the number of cases reviewed;

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

''(iii) the length of time in making determinations on those cases;

''(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

''(v) information necessary to assure that the entity meets the independence requirements (described in paragraph (3)) with respect to plans and issuers for which it conducts external review activities.

''(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of subparagraph (A)(ii), the Secretary may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external appeal entities. Such an organization shall only be certified if the organization does not certify an external appeal entity unless it meets standards as least as stringent as the standards required for certification of such an entity by the Secretary under subparagraph (A)(ii).

''(3) INDEPENDENCE REQUIREMENTS.—

''(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

''(i) the peer or entity is not affiliated with any related party;

''(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

''(iii) the plan and the issuer (if any) have no recourse against the peer or entity in connection with the external review; and

''(iv) the peer or entity does not otherwise have a conflict of interest with a related party.

''(B) RELATED PARTY.—For purposes of this paragraph, the term 'related party' means—

''(i) with respect to—

''(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

''(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

''(ii) the health care professional that provided the health care involved in the coverage decision;

''(iii) the institution at which the health care involved in the coverage decision is provided; or

''(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision.

''(C) AFFILIATED.—For purposes of this paragraph, the term 'affiliated' means, in connection with any peer or entity, having a familial, financial, or fiduciary relationship with such peer or entity.

''(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

''(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—

''(1) IN GENERAL.—The determination by an external appeal entity shall be binding on the plan (and issuer, if any) involved in the determination.

''(2) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as removing any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law, including the right to file judicial actions to enforce rights.

''(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL APPEAL ENTITY.—

''(1) MONETARY PENALTIES.—In any case in which the determination of an external appeal entity is not followed in a timely fashion by a group health plan, or by a health insurance issuer offering health insurance coverage, any named fiduciary who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external appeal entity until the date the refusal to provide the benefit is corrected.

''(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

''(A) to cease and desist from the alleged action or failure to act; and

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

''(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as removing or limiting any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law (including section 502 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

''SEC. 2804. ESTABLISHMENT OF A GRIEVANCE PROCESS.

''(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

''(2) GRIEVANCE DEFINED.—In this section, the term 'grievance' means any question, complaint, or concern brought by a participant, beneficiary, or enrollee that is not a claim for benefits.

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

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

''(2) A system to record and document, over a period of at least 3 previous years beginning two months after the date of the enactment of this Act, all grievances and appeals made and their status.

''(3) A process providing processing and resolution of grievances within 60 days.

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

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

''Subtitle B—Access to Care

''SEC. 2811. CONSUMER CHOICE OPTION.

''(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such nonnetwork coverage through another health insurance issuer.

''(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

''(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

''SEC. 2812. CHOICE OF HEALTH CARE PROFESSIONAL.

''(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

''(b) SPECIALISTS.—A group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

''SEC. 2813. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

''(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

''(i) by a nonparticipating health care provider with or without prior authorization, or

''(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

''(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

''(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment

as are required under section 1867 of such Act to stabilize the patient; or

''(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(C) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

''(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''SEC. 2814. ACCESS TO SPECIALTY CARE.

''(a) SPECIALTY CARE FOR COVERED SERVICES.—

''(1) IN GENERAL.—If—

''(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

''(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

''(C) benefits for such treatment or services are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 2818) to provide the treatment for such condition or disease or to provide such services.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality care in treating the condition or to provide physician pathology services.

''(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

''(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

''(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan or health insurance issuer shall provide the individual the option of at least three nonparticipating specialists.

''(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

''(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

''(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

''(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing special condition' means a condition or disease that—

''(A) is life-threatening, degenerative, or disabling, and

''(B) requires specialized medical care over a prolonged period of time.

''(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

''(c) STANDING REFERRALS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

''(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''SEC. 2815. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

''(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for covered gynecological care (including preventive women's health examinations) or for covered pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in gynecology or obstetrics, respectively, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological or obstetrical care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

''(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetrical care;

''(2) preclude the group health plan or health insurance issuer involved from requiring that the gynecologist or obstetrician notify the primary care health care professional or the plan of treatment decisions; or

''(3) prevent a plan or issuer from offering, in addition to physicians described in subsection (a)(1), non-physician health care professionals who are trained and experienced in gynecology or obstetrics.

''SEC. 2816. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

''SEC. 2817. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

''(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

''(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) DEFINITIONS.—For purposes of this section:

''(A) ONGOING SPECIAL CONDITION.—The term 'ongoing special condition' has the meaning given such term in section 2814(b)(3), and also includes pregnancy.

''(B) TERMINATION.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

''(3) PREGNANCY.—If—

''(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

''SEC. 2818. NETWORK ADEQUACY.

''(a) REQUIREMENT.—A group health plan, and a health insurance issuer providing health insurance coverage, shall meet such standards for network adequacy as are established by law pursuant to this section.

''(b) DEVELOPMENT OF STANDARDS.—

''(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the 'Panel').

''(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and health insurance issuers that offer health insurance coverage to ensure that—

''(A) participants, beneficiaries, and enrollees have access to a sufficient number, mix, and distribution of health care professionals and providers; and

''(B) covered items and services are available and accessible to each participant, beneficiary, and enrollee—

''(i) in the service area of the plan or issuer;

''(ii) at a variety of sites of service;

''(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

''(iv) with reasonable proximity to the residences or workplaces of enrollees; and

''(v) in a manner that takes into account the diverse needs of enrollees and reasonably assures continuity of care.

''(c) MEMBERSHIP.—

''(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Representatives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

''(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

''(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

''(d) PROCEDURES.—

''(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

''(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

''(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

''(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

''(e) ADMINISTRATION.—

''(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

''(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

''(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

''(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

''SEC. 2819. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

''No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan or under health insurance coverage provided by a health insurance issuer if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

''SEC. 2820. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage) provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan or an enrollee in health insurance coverage and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

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

''(2) ROUTINE PATIENT CARE COSTS.—For purposes of this section—

''(A) IN GENERAL.—The term 'routine patient care costs' includes the costs associated with the provision of items and services that—

''(i) would otherwise be covered under the group health plan or health insurance coverage if such items and services were not provided in connection with an approved clinical trial program; and

''(ii) are furnished according to the protocol of an approved clinical trial program.

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

''(i) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(ii) any item or service supplied without charge by the sponsor of the approved clinical trial program.

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

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

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable items or services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

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

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of the Employee Retirement Income Security Act of 1974.

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary of Health and Human Services, in consultation with the Secretary and the Secretary of the Treasury, shall analyze cancer clinical research and its cost implications for managed care, including differentiation in—

''(A) the cost of patient care in trials versus standard care;

''(B) the cost effectiveness achieved in different sites of service;

''(C) research outcomes;

''(D) volume of research subjects available in different sites of service;

''(E) access to research sites and clinical trials by cancer patients;

''(F) patient cost sharing or copayment costs realized in different sites of service;

''(G) health outcomes experienced in different sites of service;

''(H) long term health care services and costs experienced in different sites of service;

''(I) morbidity and mortality experienced in different sites of service; and

''(J) patient satisfaction and preference of sites of service.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary of Health and Human Services shall submit a report to Congress that contains—

''(A) an assessment of any incremental cost to group health plans and health insurance issuers resulting from the provisions of this section;

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

''(C) an assessment of any impact on premiums resulting from this section; and

''(D) recommendations regarding action on other diseases.

''Subtitle C—Access to Information

''SEC. 2821. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—

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

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

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

''(C) upon request, make available to participants and beneficiaries, the Secretary, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

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

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

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

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

''(C) upon request, make available to the Secretary, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c).

''(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer shall be provided to a participant, beneficiary, or enrollee free of charge at least once a year and includes the following:

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

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

''(A) those that are covered benefits ''(all of which shall be referred to by such relevant CPT and DRG codes as are available), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (all of which shall be referred to by

such relevant CPT and DRG codes as are available);

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

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

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

''(E) process for determining experimental coverage; and

''(F) use of a prescription drug formulary.

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

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

''(B) Out-of-network coverage (if any) provided by the plan or coverage.

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

''(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

''(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

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

''(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 2812(b)(2).

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

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

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

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

''(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

''(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

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

''(A) the preemption that applies under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) to certain actions arising out of the provision of health benefits; and

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

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

''(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

''(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

''(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

''(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 2801.

''(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

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

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

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

''Subtitle D—Protecting the Doctor-Patient Relationship

''SEC. 2831. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

''(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

''SEC. 2832. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

''(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

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

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

''(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

''SEC. 2833. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

''(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

''SEC. 2834. PAYMENT OF CLEAN CLAIMS.

''A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer,in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

''Subtitle E—Definitions

''SEC. 2841. DEFINITIONS.

''(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII.

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

''(1) APPLICABLE AUTHORITY.—The term 'applicable authority' means—

''(A) in the case of a group health plan, the Secretary of Health and Human Services; and

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

''(2) CLINICAL PEER.—The term 'clinical peer' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

''(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition,

procedure, or treatment under review or appeal, or

''(B) is trained and experienced in managing such condition, procedure, or treatment,

and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

''(3) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(4) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(5) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

''(6) NETWORK.—The term 'network' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

''(7) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(8) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(9) PHYSICIAN.—The term 'physician' means an allopathic or osteopathic physician.

''(10) PRACTICING PHYSICIAN.—The term 'practicing physician' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

''(11) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

''SEC. 2842. RULE OF CONSTRUCTION.

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

''(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers except to the extent that such standard or requirement prevents the application of a requirement of this title.

''(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974.

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

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

''(2) STATE.—The term 'State' includes a State, the District of Columbia, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

''SEC. 2843. EXCLUSIONS.

''(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to provide specific benefits under the terms of such plan or coverage, other than those provided under the terms of such plan or coverage.

''(b) EXCLUSION FOR FEE-FOR-SERVICE COVERAGE.—

''(1) IN GENERAL.—

''(A) GROUP HEALTH PLANS.—The provisions of sections 2811 through 2821 shall not apply to a group health plan if the only coverage offered under the plan is fee-for-service coverage (as defined in paragraph (2)).

''(B) HEALTH INSURANCE COVERAGE.—The provisions of sections 2801 through 2821 shall not apply to health insurance coverage if the only coverage offered under the coverage is fee-for-service coverage (as defined in paragraph (2)).

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

''(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

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

''(C) allows access to any provider that is lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

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

''SEC. 2844. COVERAGE OF LIMITED SCOPE PLANS.

''Only for purposes of applying the requirements of this title under sections 2707 and 2753, section 2791(c)(2)(A) shall be deemed not to apply.

''SEC. 2845. REGULATIONS.

''The Secretary of Health and Human Services shall issue such regulations as may be necessary or appropriate to carry out this title under sections 2707 and 2753. The Secretary may promulgate such regulations in the form of interim final rules as may be necessary to carry out this title in a timely manner.

''SEC. 2846. LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.

''The requirements of this title shall apply with respect to group health plans only—

''(1) in the case of a plan that is a non-Federal governmental plan (as defined in section 2791(d)(8)(C)), and

''(2) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan), except that subtitle A shall apply with respect to such coverage only to the extent it is offered in connection with a non-Federal governmental plan or a church plan.''.

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

SEC. 201. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

''SEC. 714. PATIENT PROTECTION STANDARDS.

''A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part 8 and such requirements shall be deemed to be incorporated into this section.''.

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

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subpart A of part 8 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial. For purposes of applying the previous sentence, the exceptions provided under section 732 shall be deemed to apply.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

SEC. 202. IMPROVING MANAGED CARE.

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

''PART 8—IMPROVING MANAGED CARE

''SUBPART A—GRIEVANCE AND APPEALS

''SEC. 801. UTILIZATION REVIEW ACTIVITIES.

''(a) COMPLIANCE WITH REQUIREMENTS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage in connection with such a plan, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

''(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

''(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms 'utilization review' and 'utilization review activities' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

''(b) WRITTEN POLICIES AND CRITERIA.—

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

''(2) USE OF WRITTEN CRITERIA.—

''(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate practicing physicians, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

''(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a participant or beneficiary under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the individual during the same course of treatment.

''(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for periodic evaluation at reasonable intervals of the clinical appropriateness of a sample of denials of claims for benefits.

''(c) CONDUCT OF PROGRAM ACTIVITIES.—

''(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by appropriate physician specialists who shall be selected by the plan or issuer and who shall oversee review decisions.

''(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

''(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

''(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits. This subparagraph shall not preclude any capitation arrangements between plans and providers.

''(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

''(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

''(d) DEADLINE FOR DETERMINATIONS.—

''(1) PRIOR AUTHORIZATION SERVICES.—

''(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, no later than the deadline specified in subparagraph (B). The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided.

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

''(I) receives a request for a prior authorization,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 2 business days after notification,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in section 802(c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of the request for prior authorization.

''(2) ONGOING CARE.—

''(A) CONCURRENT REVIEW.—

''(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed or electronic form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 802(c)(1)(A) to be completed before the termination or reduction takes effect.

''(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

''(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

''(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed or electronic form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

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

''(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, POST-STABILIZATION CARE, AND EMERGENCY AMBULANCE SERVICES.—For waiver of prior authorization requirements in certain cases involving emergency services, maintenance care and post-stabilization care, and emergency ambulance services, see subsections (a)(1), (b), and (c)(1) of section 813, respectively.

''(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

''(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed or electronic form and written in a manner calculated to be understood by the participant or beneficiary and shall include—

''(A) the reasons for the denial (including the clinical rationale);

''(B) instructions on how to initiate an appeal under section 802; and

''(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

''(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

''(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subpart:

''(1) CLAIM FOR BENEFITS.—The term 'claim for benefits' means any request for coverage (including authorization of coverage), or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage offered in connection with such a plan.

''(2) DENIAL OF CLAIM FOR BENEFITS.—The term 'denial' means, with respect to a claim for benefits, a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide or pay for benefits (including items and services) required to be provided or paid for under this part.

''SEC. 802. INTERNAL APPEALS PROCEDURES.

''(a) RIGHT OF REVIEW.—

''(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage in connection with such a plan—

''(A) shall provide adequate notice in written or electronic form to any participant or beneficiary under such plan whose claim for benefits under the plan or coverage has been denied (within the meaning of section 801(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in layman's terms to be understood by the participant or beneficiary; and

''(B) shall afford such a participant or beneficiary (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to

provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity of not less than 180 days to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

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

''(b) INTERNAL REVIEW PROCESS.—

''(1) CONDUCT OF REVIEW.—

''(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual (who shall be a physician in a case involving medical judgment) who has been selected by the plan or issuer and who did not make the initial denial in the internally appealable decision, except that in the case of limited scope coverage (as defined in subparagraph (B)) an appropriate specialist shall review the decision.

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

''(2) TIME LIMITS FOR INTERNAL REVIEWS.—

''(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed or electronic form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

''(B) DEADLINE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the earliest date as of which the request for prior authorization has been received and all necessary information has been provided. The provider involved shall provide timely access to information relevant to the matter of the review decision.

''(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

''(I) receives a request for internal review,

''(II) determines that additional information is necessary to complete the review and make the determination on the request,

''(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

''(IV) requires the requester to submit specified information not later than 48 hours after notification,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

''(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of request for review.

''(c) EXPEDITED REVIEW PROCESS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

''(A) in which, as determined by the plan or issuer or as certified in writing by a treating physician, the application of the normal timeframe for making the determination could seriously jeopardize the life or health of the participant or beneficiary or such individual's ability to regain maximum function; or

''(B) described in section 801(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

''(2) PROCESS.—Under such procedures—

''(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

''(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

''(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

''(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 48 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

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

''SEC. 803. EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with such a plan, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made (within a reasonable period not to exceed 365 days) either by the plan or issuer or by the participant or beneficiary (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent).

''(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'externally appealable decision' means a denial of claim for benefits (as defined in section 801(f)(2)), if—

''(i) the item or service involved is covered under the plan or coverage,

''(ii) the amount involved exceeds $100, increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from such index for September 2000, and

''(iii) the requirements of subparagraph (B) are met with respect to such denial.

Such term also includes a failure to meet an applicable deadline for internal review under section 802 or such standards as are established pursuant to section 818.

''(B) REQUIREMENTS.—For purposes of subparagraph (A)(iii), the requirements of this subparagraph are met with respect to a denial of a claim for benefits if—

''(i) the denial is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or

''(ii) in such denial, the decision as to whether an item or service is covered involves a medical judgment.

''(C) EXCLUSIONS.—The term 'externally appealable decision' does not include—

''(i) specific exclusions or express limitations on the amount, duration, or scope of coverage; or

''(ii) a decision regarding eligibility for any benefits.

''(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 802(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 802, but only if the decision is made in a timely basis consistent with the deadlines provided under this subpart.

''(4) FILING FEE REQUIREMENT.—

''(A) IN GENERAL.—A plan or issuer may condition the use of an external appeal process upon payment in advance to the plan or issuer of a $25 filing fee.

''(B) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse the denial of a claim for benefits which is the subject of the appeal.

''(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

''(1) USE OF QUALIFIED EXTERNAL APPEAL ENTITY.—

''(A) IN GENERAL.—The external appeal process under this section of a plan or issuer shall be conducted between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)). Nothing in this subsection shall be construed as requiring that such procedures provide for the selection for any plan of more than one such entity.

''(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The Secretary shall implement procedures to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner.

''(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of this paragraph shall be consistent with the standards the Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. All costs of the process (except those incurred by the participant, beneficiary, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant or beneficiary. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

''(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the Secretary that include at least the following:

''(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination described in subparagraph (B) based on evidence described in subparagraphs (C) and (D).

''(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is appropriate for the medical condition of the patient involved (as determined by the entity) taking into account as of the time of the entity's determination the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraphs (C) and (D). If the entity determines the decision is appropriate for such condition, the entity shall affirm the decision and to the extent that the entity determines the decision is not appropriate for such condition, the entity shall reverse the decision. Nothing in this subparagraph shall be construed as providing for coverage of items or services not provided or covered by the plan or issuer.

''(C) REQUIRED CONSIDERATION OF CERTAIN MATTERS.—In making such determination, the external appeal entity shall consider, but not be bound by—

''(i) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms;

''(ii) the decision made by the plan or issuer upon internal review under section 802 and any guidelines or standards used by the plan or issuer in reaching such decision; and

''(iii) the opinion of the individual's treating physician or health care professional.

The entity also shall consider any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed. The entity also shall consider the results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

''(D) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

''(i) The results of professional consensus conferences.

''(ii) Practice and treatment policies.

''(iii) Community standard of care.

''(iv) Generally accepted principles of professional medical practice consistent with the best practice of medicine.

''(v) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

''(vi) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

''(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—

''(i) IN GENERAL.—A qualified external appeal entity shall determine—

''(I) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

''(II) whether an externally appealable decision involves an expedited appeal;

''(III) for purposes of initiating an external review, whether the internal review process has been completed; and

''(IV) whether the item or services is covered under the plan or coverage.

''(ii) CONSTRUCTION.—Nothing in a determination by a qualified external appeal entity under this section shall be construed as authorizing, or providing for, coverage of items and services for which benefits are not provided under the plan or coverage.

''(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

''(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide to the external appeal entity timely access to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity. The provider involved shall provide to the external appeal entity timely access to information relevant to the matter of the externally appealable decision, as determined by the entity.

''(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

''(i) be made orally or in written or electronic form and, if it is made orally, shall be supplied to the parties in written or electronic form as soon as possible;

''(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 48 hours after the time) of requesting an external appeal of the decision;

''(iii) state, in layperson's language, the scientific rationale for such determination as well as the basis for such determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

''(iv) inform the participant or beneficiary of the individual's rights (including any limitation on such rights) to seek binding arbitration or further review by the courts (or other process) of the external appeal determination.

''(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity determines that a denial of a claim for benefits was not reasonable and reverses the denial, the plan or issuer—

''(i) shall (upon the receipt of the determination) authorize benefits in accordance with such determination;

''(ii) shall take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

''(iii) shall submit information to the entity documenting compliance with the entity's determination and this subparagraph.

''(J) CONSTRUCTION.—Nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are not provided under the plan or coverage.

''(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified external appeal entity' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

''(A) The entity meets the independence requirements of paragraph (3).

''(B) The entity conducts external appeal activities through at least three clinical peers who are practicing physicians.

''(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

''(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

''(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to a group health plan or a health insurance issuer in connection with a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified), under such standards as may be prescribed by the Secretary, as meeting the requirements of paragraph (1)—

''(i) by the Secretary;

''(ii) under a process recognized or approved by the Secretary; or

''(iii) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph), if elected by the entity.

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

''(i) the number of cases reviewed;

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

''(iii) the length of time in making determinations on those cases;

''(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

''(v) information necessary to assure that the entity meets the independence requirements (described in paragraph (3)) with respect to plans and issuers for which it conducts external review activities.

''(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of subparagraph (A)(iii), the Secretary shall provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external appeal entities. Such an organization shall only be certified if the organization does not certify an external appeal entity unless it meets standards at least as stringent as the standards required for certification of such an entity by the Secretary under subparagraph (A)(i).

''(D) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting the Secretary to delegate certification or regulatory authority under clause (i) of such subparagraph to any person outside the Department of Labor.

''(3) INDEPENDENCE REQUIREMENTS.—

''(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

''(i) the peer or entity is not affiliated with any related party;

''(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

''(iii) the plan and the issuer (if any) have no recourse against the peer or entity in connection with the external review; and

''(iv) the peer or entity does not otherwise have a conflict of interest with a related party.

''(B) RELATED PARTY.—For purposes of this paragraph, the term 'related party' means—

''(i) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

''(ii) the health care professional that provided the health care involved in the coverage decision;

''(iii) the institution at which the health care involved in the coverage decision is provided; or

''(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision.

''(C) AFFILIATED.—For purposes of this paragraph, the term 'affiliated' means, in connection with any peer or entity, having a familial, financial, or fiduciary relationship with such peer or entity.

''(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty,

function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

''(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—

''(1) IN GENERAL.—The determination by an external appeal entity shall be binding on the plan (and issuer, if any) involved in the determination.

''(2) PROTECTION OF LEGAL RIGHTS.—Nothing in this subpart shall be construed as removing any legal rights of participants, beneficiaries, and others under State or Federal law, including the right to file judicial actions to enforce rights.

''(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL APPEAL ENTITY.—

''(1) MONETARY PENALTIES.—In any case in which the determination of an external appeal entity is not followed in a timely fashion by a group health plan, or by a health insurance issuer offering health insurance coverage in connection with such a plan, any named fiduciary who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant or beneficiary for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external appeal entity until the date the refusal to provide the benefit is corrected.

''(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant or beneficiary with respect to a group health plan, or a health insurance issuer offering health insurance coverage in connection with such a plan, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subpart, or has failed to take an action for which such person is responsible under the plan, coverage, or this part and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

''(A) to cease and desist from the alleged action or failure to act; and

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

''(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subpart shall be construed as removing or limiting any legal rights of participants, beneficiaries, and others under State or Federal law (including section 502), including the right to file judicial actions to enforce rights.

''SEC. 804. ESTABLISHMENT OF A GRIEVANCE PROCESS.

''(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants or beneficiaries or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

''(2) GRIEVANCE DEFINED.—In this section, the term 'grievance' means any question, complaint, or concern brought by a participant or beneficiary that is not a claim for benefits.

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

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

''(2) A system to record and document, over a period of at least 3 previous years beginning two months after the date of the enactment of this Act, all grievances and appeals made and their status.

''(3) A process providing processing and resolution of grievances within 60 days.

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

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

''SUBPART B—ACCESS TO CARE

''SEC. 812. CHOICE OF HEALTH CARE PROFESSIONAL.

''(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage in connection with such a plan, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer shall permit each participant and beneficiary to designate any participating primary care provider who is available to accept such individual.

''(b) SPECIALISTS.—A group health plan and a health insurance issuer that offers health insurance coverage in connection with such a plan shall permit each participant or beneficiary to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

''SEC. 813. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer in connection with such a plan, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

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

''(i) by a nonparticipating health care provider with or without prior authorization, or

''(ii) by a participating health care provider without prior authorization,

the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

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

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

''(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

''(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(C) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer in connection with such a plan, with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant or beneficiary other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer in connection with such a plan, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

''(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term 'emergency ambulance services' means ambulance services (as defined for purposes of section

1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

"SEC. 814. ACCESS TO SPECIALTY CARE.

''(a) SPECIALTY CARE FOR COVERED SERVICES.—

''(1) IN GENERAL.—If—

''(A) an individual is a participant or beneficiary under a group health plan or is covered under health insurance coverage offered by a health insurance issuer in connection with such a plan,

''(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

''(C) benefits for such treatment or services are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 818) to provide the treatment for such condition or disease or to provide such services.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality care in treating the condition or to provide physician pathology services.

''(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

''(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

''(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan or health insurance issuer shall provide the individual the option of at least three nonparticipating specialists.

''(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

''(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage in connection with such a plan, shall have a procedure by which an individual who is a participant or beneficiary and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

''(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

''(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing special condition' means a condition or disease that—

''(A) is life-threatening, degenerative, or disabling, and

''(B) requires specialized medical care over a prolonged period of time.

''(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant or beneficiary and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

''(c) STANDING REFERRALS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, shall have a procedure by which an individual who is a participant or beneficiary and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

''(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

"SEC. 815. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, requires or provides for a participant or beneficiary to designate a participating primary care health care professional, the plan or issuer—

''(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for covered gynecological care (including preventive women's health examinations) or for covered pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in gynecology or obstetrics, respectively, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological or obstetrical care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

''(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetrical care;

''(2) preclude the group health plan or health insurance issuer involved from requiring that the gynecologist or obstetrician notify the primary care health care professional or the plan of treatment decisions; or

''(3) prevent a plan or issuer from offering, in addition to physicians described in subsection (a)(1), non-physician health care professionals who are trained and experienced in gynecology or obstetrics.

"SEC. 816. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, requires or provides for a participant or beneficiary to designate a participating primary care provider for a child of such individual, the plan or issuer shall permit the participant or beneficiary to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

"SEC. 817. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage in connection with such a plan, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant or beneficiary in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

''(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

''(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan

and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) DEFINITIONS.—For purposes of this section:

''(A) ONGOING SPECIAL CONDITION.—The term 'ongoing special condition' has the meaning given such term in section 814(b)(3), and also includes pregnancy.

''(B) TERMINATION.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

''(3) PREGNANCY.—If—

''(A) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

''SEC. 818. NETWORK ADEQUACY.

''(a) REQUIREMENT.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with such a plan, shall meet such standards for network adequacy as are established by law pursuant to this section.

''(b) DEVELOPMENT OF STANDARDS.—

''(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the 'Panel').

''(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and health insurance issuers that offer health insurance coverage in connection with such a plan to ensure that—

''(A) participants and beneficiaries have access to a sufficient number, mix, and distribution of health care professionals and providers; and

''(B) covered items and services are available and accessible to each participant and beneficiary—

''(i) in the service area of the plan or issuer;

''(ii) at a variety of sites of service;

''(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

''(iv) with reasonable proximity to the residences or workplaces of participants and beneficiaries; and

''(v) in a manner that takes into account the diverse needs of such individuals and reasonably assures continuity of care.

''(c) MEMBERSHIP.—

''(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Representatives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

''(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

''(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

''(d) PROCEDURES.—

''(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

''(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

''(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

''(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

''(e) ADMINISTRATION.—

''(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

''(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

''(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

''(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

''SEC. 819. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

''No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan or under health insurance coverage provided by a health insurance issuer in connection with such a plan if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

''SEC. 820. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (or a health insurance issuer offering health insurance coverage in connection with such a plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

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

''(2) ROUTINE PATIENT CARE COSTS.—For purposes of this section—

''(A) IN GENERAL.—The term 'routine patient care costs' includes the costs associated with the provision of items and services that—

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

''(ii) are furnished according to the protocol of an approved clinical trial program.

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

''(i) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(ii) any item or service supplied without charge by the sponsor of the approved clinical trial program.

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

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

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable items or services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

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

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''SUBPART C—ACCESS TO INFORMATION

''SEC. 821. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—

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

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

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

''(C) upon request, make available to participants and beneficiaries, the Secretary, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

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

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

''(A) provide to participants and beneficiaries enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b);

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

''(C) upon request, make available to the Secretary, to individuals who are prospective participants and beneficiaries, and to the public the information described in subsection (b) or (c).

''(3) EMPLOYERS.—Effective 5 years after the date this part first becomes effective, each employer (other than an employer described in paragraph (1) of subsection (d)) shall provide to each employee at least annually information (consistent with such subsection) on the amount that the employer contributes on behalf of the employee (and any dependents of the employee) for health benefits coverage.

''(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer shall be provided to a participant or beneficiary free of charge at least once a year and includes the following:

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

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

''(A) those that are covered benefits ''(all of which shall be referred to by such relevant CPT and DRG codes as are available), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (all of which shall be referred to by such relevant CPT and DRG codes as are available);

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

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

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

''(E) process for determining experimental coverage; and

''(F) use of a prescription drug formulary.

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

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

''(B) Out-of-network coverage (if any) provided by the plan or coverage.

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

''(D) The procedures for participants and beneficiaries to select, access, and change participating primary and specialty providers.

''(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

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

''(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 812(b)(2).

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

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

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

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

''(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

''(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

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

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

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

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

''(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants and beneficiaries in seeking information or authorization for treatment.

''(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

''(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

''(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 801.

''(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

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

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

''(d) EMPLOYER INFORMATION.—

''(1) SMALL EMPLOYER EXEMPTION.—Subsection (a)(3) shall not apply to an employer that is a small employer (as defined in section 712(c)(1)(B)) or would be such an employer if '100' were substituted for '50' in such section.

''(2) COMPUTATION.—The amount described in subsection (a)(3) may be computed on an average, per employee basis, and may be based on rules similar to the rules applied in computing the applicable premium under section 604.

''(3) FORM OF DISCLOSURE.—The information under subsection (a)(3) may be provided in any reasonable form, including as part of the summary plan description, a letter, or information accompanying a W–2 form.

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

''SUBPART D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

''SEC. 831. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage offered in connection with such a plan (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

''(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

''SEC. 832. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with such a plan shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

''(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

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

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

''(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

''SEC. 833. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with such a plan may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

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

''(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

''SEC. 834. PAYMENT OF CLEAN CLAIMS.

''A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant or beneficiary with respect to benefits covered by the plan or issuer,in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant or beneficiary as well as claims referred to in such subparagraph.

''SUBPART E—DEFINITIONS

''SEC. 841. DEFINITIONS.

''(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 733 shall apply for purposes of this part in the same manner as they apply for purposes of part 7.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this part:

''(1) APPLICABLE AUTHORITY.—The term 'applicable authority' means—

''(A) in the case of a group health plan, the Secretary of Labor; and

''(B) in the case of a health insurance issuer with respect to a specific provision of this part, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

''(2) CLINICAL PEER.—The term 'clinical peer' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

''(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal, or

''(B) is trained and experienced in managing such condition, procedure, or treatment,

and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

''(3) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(4) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

''(5) NETWORK.—The term 'network' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants or beneficiaries.

''(6) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

''(7) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan or health insurance coverage offered by a health insurance issuer in connection with such a plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

''(8) PHYSICIAN.—The term 'physician' means an allopathic or osteopathic physician.

''(9) PRACTICING PHYSICIAN.—The term 'practicing physician' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

''(10) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of

obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

"SEC. 842. RULE OF CONSTRUCTION.

''Nothing in this part or section 714 shall be construed to affect or modify the provisions of section 514.

"SEC. 843. EXCLUSIONS.

''(a) NO BENEFIT REQUIREMENTS.—Nothing in this part shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage in connection with such a plan to provide specific benefits under the terms of such plan or coverage, other than those provided under the terms of such plan or coverage.

''(b) EXCLUSION FOR FEE-FOR-SERVICE COVERAGE.—

''(1) IN GENERAL.—

''(A) GROUP HEALTH PLANS.—The provisions of sections 811 through 821 shall not apply to a group health plan if the only coverage offered under the plan is fee-for-service coverage (as defined in paragraph (2)).

''(B) HEALTH INSURANCE COVERAGE.—The provisions of sections 801 through 821 shall not apply to health insurance coverage if the only coverage offered under the coverage is fee-for-service coverage (as defined in paragraph (2)).

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

''(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

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

''(C) allows access to any provider that is lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

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

"SEC. 844. COVERAGE OF LIMITED SCOPE PLANS.

''Only for purposes of applying the requirements of this part under section 714, section 733(c)(2)(A) shall be deemed not to apply.

"SEC. 845. REGULATIONS.

''(a) REGULATIONS.—The Secretary of Labor shall issue such regulations as may be necessary or appropriate to carry out this part under section 714. The Secretary may promulgate such regulations in the form of interim final rules as may be necessary to carry out this part in a timely manner.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—IMPROVING MANAGED CARE

''SUBPART A—GRIEVANCE AND APPEALS

''Sec. 801. Utilization review activities.
''Sec. 802. Internal appeals procedures.
''Sec. 803. External appeals procedures.
''Sec. 804. Establishment of a grievance process.

''SUBPART B—ACCESS TO CARE

''Sec. 812. Choice of health care professional.
''Sec. 813. Access to emergency care.
''Sec. 814. Access to specialty care.
''Sec. 815. Access to obstetrical and gynecological care.
''Sec. 816. Access to pediatric care.
''Sec. 817. Continuity of care.
''Sec. 818. Network adequacy.
''Sec. 819. Access to experimental or investigational prescription drugs.
''Sec. 820. Coverage for individuals participating in approved cancer clinical trials.

''SUBPART C—ACCESS TO INFORMATION

''Sec. 821. Patient access to information.

''SUBPART D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

''Sec. 831. Prohibition of interference with certain medical communications.
''Sec. 832. Prohibition of discrimination against providers based on licensure.
''Sec. 833. Prohibition against improper incentive arrangements.
''Sec. 834. Payment of clean claims.

''SUBPART E—DEFINITIONS

''Sec. 841. Definitions.
''Sec. 842. Preemption; State flexibility; construction.
''Sec. 843. Exclusions.
''Sec. 844. Coverage of limited scope plans.
''Sec. 845. Regulations.

SEC. 203. AVAILABILITY OF COURT REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

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

''(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan or plan sponsor (not including a participating physician, other than a physician who participated in making the final decision under section 802 pursuant to section 802(b)(1)(A)) and who, under the plan, has authority to make final decisions under 802—

''(i) fails to exercise ordinary care in making an incorrect determination in the case of a participant or beneficiary that an item or service is excluded from coverage under the terms of the plan based on the fact that the item or service—

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

''(II) would constitute experimental treatment or technology (as defined under the plan), or

''(III) is not a covered benefit, or

''(ii) fails to exercise ordinary care to ensure that—

''(I) any denial of claim for benefits (within the meaning of section 801(f)), or

''(II) any decision by the plan on a request, made by a participant or beneficiary under section 802 or 803, for a reversal of an earlier decision of the plan,

is made and issued to the participant or beneficiary (in such form and manner as may be prescribed in regulations of the Secretary) before the end of the applicable period specified in section 801, 802, or 803, and

''(B) such failure is the proximate cause of substantial harm to, or wrongful death of, the participant or beneficiary,

such person shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (10)). For purposes of this subsection, the term 'final decision' means, with respect to a group health plan, the sole final decision of the plan under section 802.

''(2) ORDINARY CARE.—For purposes of this subsection, the term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent individual acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

''(3) SUBSTANTIAL HARM.—The term 'substantial harm' means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain.

''(4) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

''(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment),

''(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1), or

''(iii) any cause of action in connection with the provision of excepted benefits described in section 733(c), other than those described in section 733(c)(2).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) commenced against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment), but only if—

''(i) such action is based on the direct participation of the employer or other plan sponsor (or employee of the employer or plan sponsor) in the final decision of the plan with respect to a specific participant or beneficiary on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the decision on the claim resulted in substantial harm to, or the wrongful death of, such participant or beneficiary.

''(C) DIRECT PARTICIPATION.—For purposes of this subsection, the term 'direct participation' means, in connection with a final decision under section 802, the actual making of such final decision as a plan fiduciary or the actual exercise of final controlling authority in the approval of such final decision. In determining whether an employer or other plan sponsor (or employee of an employer or other plan sponsor) is engaged in direct participation in the final decision of the plan on a claim, the employer or plan sponsor (or employee) shall not be construed to be engaged in such direct participation (and to be liable for any damages whatsoever) because of any form of decisionmaking or other conduct, whether or not fiduciary in nature, that does not involve a final decision with respect to a specific claim for benefits by a specific participant or beneficiary, including (but not limited to)—

''(i) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

''(ii) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(iii) any participation by the employer or other plan sponsor (or employee) in the creation, continuation, modification, or termination of the plan or of any coverage, benefit, or item or service covered by the plan;

''(iv) any participation by the employer or other plan sponsor (or employee) in the design of any coverage, benefit, or item or service covered by the plan, including the amount of copayment and limits connected with such coverage, and the specification of any protocol, procedure, or policy for determining whether any such coverage, benefit,

or item or service is medically necessary and appropriate or is experimental or investigational;

''(v) any action by an agent of the employer or plan sponsor in making such a final decision on behalf of such employer or plan sponsor;

''(vi) any decision by an employer or plan sponsor (or employee) or agent acting on behalf of an employer or plan sponsor either to authorize coverage for, or to intercede or not to intercede as an advocate for or on behalf of, any specific participant or beneficiary (or group of participants or beneficiaries) under the plan;

''(vii) the approval of, or participation in the approval of, the plan provisions defining medical necessity or of policies or procedures that have a direct bearing on the outcome of the final decision; or

''(viii) any other form of decisionmaking or other conduct performed by the employer or other plan sponsor (or employee) in connection with the plan or coverage involved unless it involves the making of a final decision of the plan consisting of a failure described in clause (i) or (ii) of paragraph (1)(A) as to specific participants or beneficiaries who suffer substantial harm or wrongful death as a proximate cause of such decision.

''(5) REQUIRED DEMONSTRATION OF DIRECT PARTICIPATION.—An action against an employer or plan sponsor (or employee thereof) under this subsection shall be immediately dismissed—

''(A) in the absence of an allegation in the complaint of direct participation by the employer or plan sponsor in the final decision of the plan with respect to a specific participant or beneficiary who suffers substantial harm or wrongful death, or

''(B) upon a demonstration to the court that such employer or plan sponsor (or employee) did not directly participate in the final decision of the plan.

''(6) TREATMENT OF THIRD-PARTY PROVIDERS OF NONDISCRETIONARY ADMINISTRATIVE SERVICES.—Paragraph (1) does not authorize any action against any person providing nondiscretionary administrative services to employers or other plan sponsors.

''(7) REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(A) IN GENERAL.—Paragraph (1) applies in the case of any cause of action only if all remedies under section 503 (including remedies under sections 802 and 803, made applicable under section 714) with respect to such cause of action have been exhausted.

''(B) EXTERNAL REVIEW REQUIRED.—For purposes of subparagraph (A), administrative remedies under section 503 shall not be deemed exhausted until available remedies under section 803 have been elected and are exhausted by issuance of a final determination by an external appeal entity under such section.

''(C) CONSIDERATION OF ADMINISTRATIVE DETERMINATIONS.—Any determinations made under section 802 or 803 made while an action under this paragraph is pending shall be given due consideration by the court in such action.

''(8) USE OF EXTERNAL APPEAL ENTITY IN ESTABLISHING ABSENCE OF SUBSTANTIAL HARM OR CAUSATION IN LITIGATION.—

''(A) IN GENERAL.—In any action under this subsection by an individual in which damages are sought on the basis of substantial harm to the individual, the defendant may obtain (at its own expense), under procedures similar to procedures applicable under section 803, a determination by a qualified external appeal entity (as defined in section 803(c)(1)) that has not been involved in any stage of the grievance or appeals process which resulted in such action as to—

''(i) whether such substantial harm has been sustained, and

''(ii) whether the proximate cause of such injury was the result of the failure of the defendant to exercise ordinary care, as described in paragraph (1)(A).

''(B) EFFECT OF FINDING IN FAVOR OF DEFENDANT.—If the external appeal entity determines that such an injury has not been sustained or was not proximately caused by such a failure, such a finding shall be an affirmative defense, and the action shall be dismissed forthwith unless such finding is overcome upon a showing of clear and convincing evidence to the contrary. Notwithstanding subsection (g), in any case in which the plaintiff fails in any attempt to make such a showing to the contrary, the court shall award to the defendant reasonable attorney's fees and the costs of the action incurred in connection with such failed showing.

''(9) REBUTTABLE PRESUMPTION.—In the case of any action commenced pursuant to paragraph (1), there shall be a rebuttable presumption in favor of the decision of the external appeal entity rendered upon completion of any review elected under section 803 and such presumption may be overcome only upon a showing of clear and convincing evidence to the contrary.

''(10) MAXIMUM NONECONOMIC DAMAGES.—Total liability for noneconomic loss under this subsection in connection with any failure with respect to any participant or beneficiary may not exceed the lesser of—

''(A) $500,000, or

''(B) 2 times the amount of economic loss. The dollar amount under subparagraph (A), shall be increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from such index for September 2000

''(11) PROHIBITION OF AWARD OF PUNITIVE DAMAGES.—

''(A) GENERAL RULE.—Except as provided in this paragraph, nothing in this subsection shall be construed as authorizing a cause of action for punitive, exemplary, or similar damages.

''(B) EXCEPTION.—Punitive damages are authorized in any case described in paragraph (1)(A)(ii)(II) in which the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with a conscious, flagrant indifference to the rights or safety of others was the proximate cause of the harm that is the subject of the action and that such conduct was contrary to the recommendations of an external appeal entity issued in the determination in such case rendered pursuant to section 803.

''(C) LIMITATION ON AMOUNT.—

''(i) IN GENERAL.—The amount of punitive damages that may be awarded in an action described in subparagraph (B) may not exceed the greater of—

''(I) 2 times the sum of the amount awarded to the claimant for economic loss; or

''(II) $250,000.

''(ii) SPECIAL RULE.—Notwithstanding clause (i), in any action described in subparagraph (B) against an individual whose net worth does not exceed $500,000 or against an owner of an unincorporated business, or any partnership, corporation, association, unit of local government, or organization which has fewer that 25 employees, the punitive damages shall not exceed the lesser of—

''(I) 2 times the amount awarded to the claimant for economic loss; or

''(II) $250,000.

''(iii) CONTROLLED GROUPS.—

''(I) IN GENERAL.—For the purpose of determining the applicability of clause (ii) to any employer, in determining the number of employees of an employer who is a member of a controlled group, the employees of any person in such group shall be deemed to be employees of the employer.

''(II) CONTROLLED GROUP.—For purposes of subclause (I), the term 'controlled group' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

''(D) EXCEPTION FOR INSUFFICIENT AWARD IN CASES OF EGREGIOUS CONDUCT.—

''(i) DETERMINATION BY COURT.—If the court makes a determination, based on clear and convincing evidence and after considering each of the factors in subparagraph (E), that the application of subparagraph (C) would result in an award of punitive damages that is insufficient to punish the egregious conduct of the defendant against whom the punitive damages are to be awarded or to deter such conduct in the future, the court shall determine the additional amount of punitive damages (referred to in this subparagraph as the 'additional amount') in excess of the amount determined in accordance with subparagraph (C) to be awarded against the defendant in a separate proceeding in accordance with this subparagraph.

''(ii) ABSOLUTE LIMIT ON PUNITIVES.—Nothing in this subtitle shall be construed to authorize the court to award an additional amount greater than an amount equal to the maximum amount applicable under subparagraph (C).

''(iii) REQUIREMENTS FOR AWARDING ADDITIONAL AMOUNT.—If the court awards an additional amount pursuant to this subparagraph, the court shall state its reasons for setting the amount of the additional amount in findings of fact and conclusions of law.

''(E) FACTORS FOR CONSIDERATION IN CASES OF EGREGIOUS CONDUCT.—In any proceeding under subparagraph (D), the matters to be considered by the court shall include (but are not limited to)—

''(i) the extent to which the defendant acted with actual malice;

''(ii) the likelihood that serious harm would arise from the conduct of the defendant;

''(iii) the degree of the awareness of the defendant of that likelihood;

''(iv) the profitability of the misconduct to the defendant;

''(v) the duration of the misconduct and any concurrent or subsequent concealment of the conduct by the defendant;

''(vi) the attitude and conduct of the defendant upon the discovery of the misconduct and whether the misconduct has terminated;

''(vii) the financial condition of the defendant; and

''(viii) the cumulative deterrent effect of other losses, damages, and punishment suffered by the defendant as a result of the misconduct, reducing the amount of punitive damages on the basis of the economic impact and severity of all measures to which the defendant has been or may be subjected, including—

''(I) compensatory and punitive damage awards to similarly situated claimants;

''(II) the adverse economic effect of stigma or loss of reputation;

''(III) civil fines and criminal and administrative penalties; and

''(IV) stop sale, cease and desist, and other remedial or enforcement orders.

''(F) APPLICATION BY COURT.—This paragraph shall be applied by the court and, in the case of a trial by jury, application of this paragraph shall not be disclosed to the jury.

''(G) LIMITATION ON PUNITIVE DAMAGES.—No person shall be liable for punitive, exemplary, or similar damages in an action under this subsection based on any failure described in paragraph (1) if such failure was in compliance with the recommendations of an external appeal entity issued in a determination under section 803.

''(H) BIFURCATION AT REQUEST OF ANY PARTY.—

''(i) IN GENERAL.—At the request of any party the trier of fact in any action that is subject to this paragraph shall consider in a separate proceeding, held subsequent to the determination of the amount of compensatory damages, whether punitive damages are to be awarded for the harm that is the subject of the action and the amount of the award.

''(ii) INADMISSIBILITY OF EVIDENCE RELATIVE ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PROCEEDING CONCERNING COMPENSATORY DAMAGES.—If any party requests a separate proceeding under clause (i), in a proceeding to determine whether the claimant may be awarded compensatory damages, any evidence, argument, or contention that is relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible.

''(12) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after the later of—

''(A) 1 year after (i) the date of the last action which constituted a part of the failure, or (ii) in the case of an omission, the latest date on which the fiduciary could have cured the failure, or

''(B) 1 year after the earliest date on which the plaintiff first knew, or reasonably should have known, of the substantial harm resulting from the failure.

''(13) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by a fiduciary which consists of full compliance with the reversal under section 803 of a denial of claim for benefits (within the meaning of section 801(f)).

''(14) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action for the failure to provide an item or service which is not covered under the group health plan involved.

''(15) PROTECTION OF MEDICAL MALPRACTICE AND SIMILAR ACTIONS UNDER STATE LAW.—This subsection shall not be construed to preclude any action under State law (as defined in section 514(c)(1)) not otherwise preempted under this title with respect to the duty (if any) under such State law imposed on any person to exercise a specified standard of care when making a health care treatment decision in any case in which medical services are provided by such person or in any case in which such decision affects the quality of care or treatment provided or received.

''(16) COEXISTING ACTIONS IN FEDERAL AND STATE COURTS DISALLOWED.—

''(A) PRECEDENCE OF FEDERAL ACTION.—An action may be commenced under this subsection only if no action for damages has been commenced by the plaintiff under State law (as defined in section 514(c)(1)) based on the same substantial harm.

''(B) ACTIONS UNDER STATE LAW SUPERSEDED.—Upon the commencement of any action under this subsection, this subsection supersedes any action authorized under State law (as so defined) against any person based on the same substantial harm during the pendency of the action commenced under this subsection.

''(C) DOUBLE RECOVERY OF DAMAGES PRECLUDED.—This subsection supersedes any action under State law (as so defined) for damages based on any substantial harm to the extent that damages for such substantial harm have been recovered in an action under this subsection.

''(17) LIMITATION ON RELIEF WHERE DEFENDANT'S POSITION PREVIOUSLY SUPPORTED UPON EXTERNAL REVIEW.—In any case in which the court finds the defendant to be liable in an action under this subsection, to the extent that such liability is based on a finding by the court of a particular failure described in paragraph (1) and such finding is contrary to a determination by an external review entity in a decision previously rendered under section 803 with respect to such defendant, no relief shall be available under this subsection in addition to the relief otherwise available under subsection (a)(1)(B).''.

(b) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of such Act (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the date of the enactment of this Act.

SEC. 204. AVAILABILITY OF BINDING ARBITRATION.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this Act) is amended further—

(1) in subsection (a), by inserting ''IN GENERAL.—'' after ''(a)'';

(2) in subsection (b), by striking ''(b) In the case'' and inserting the following:

''(b) GROUP HEALTH PLANS.—

''(1) IN GENERAL.—In the case''; and

(3) by adding at the end of subsection (b) the following:

''(2) BINDING ARBITRATION PERMITTED AS ALTERNATIVE MEANS OF DISPUTE RESOLUTION.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements of the preceding provisions of this section relating to review of any adverse coverage decision rendered by or under the plan, if—

''(i) in lieu of the procedures otherwise provided under the plan in accordance with such provisions and in lieu of any subsequent review of the matter by a court under section 502—

''(I) the aggrieved participant or beneficiary elects in the request for the review a procedure by which the dispute is resolved by binding arbitration which is available under the plan with respect to similarly situated participants and beneficiaries and which meets the requirements of subparagraph (B); or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of binding arbitration which meets the requirements of subparagraph (B); and

''(ii) the additional requirements of subparagraph (B) are met.

''(B) ADDITIONAL REQUIREMENTS.—The Secretary shall prescribe by regulation requirements for arbitration procedures under this paragraph, including at least the following requirements:

''(i) ARBITRATION PANEL.—The arbitration shall be conducted by an arbitration panel meeting the requirements of subparagraph (C).

''(ii) FAIR PROCESS; DE NOVO DETERMINATION.—The procedure shall provide for a fair, de novo determination.

''(iii) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to the arbitration procedure—

''(I) may submit and review evidence related to the issues in dispute;

''(II) may use the assistance or representation of one or more individuals (any of whom may be an attorney); and

''(III) may make an oral presentation.

''(iv) PROVISION OF INFORMATION.—The plan shall provide timely access to all its records relating to the matters under arbitration and to all provisions of the plan relating to such matters.

''(v) TIMELY DECISIONS.—A determination by the arbitration panel on the decision shall—

''(I) be made in writing;

''(II) be binding on the parties; and

''(III) be made in accordance with the medical exigencies of the case involved.

''(vi) EXHAUSTION OF EXTERNAL REVIEW REQUIRED.—The arbitration procedures under this paragraph shall not be available to party unless the party has exhausted external review procedures under section 804.

''(vii) VOLUNTARY ELECTION.—A group health plan may not require, through the plan document, a contract, or otherwise, that a participant or beneficiary make the election described in subparagraph (A)(i)(I).

''(C) ARBITRATION PANEL.—

''(i) IN GENERAL.—Arbitrations commenced pursuant to this paragraph shall be conducted by a panel of arbitrators selected by the parties made up of 3 individuals, including at least one practicing physician and one practicing attorney.

''(ii) QUALIFICATIONS.—Any individual who is a member of an arbitration panel shall meet the following requirements:

''(I) There is no real or apparent conflict of interest that would impede the individual conducting arbitration independent of the plan and meets the independence requirements of clause (iii).

''(II) The individual has sufficient medical or legal expertise to conduct the arbitration for the plan on a timely basis.

''(III) The individual has appropriate credentials and has attained recognized expertise in the applicable medical or legal field.

''(IV) The individual was not involved in the initial adverse coverage decision or any other review thereof.

''(iii) INDEPENDENCE REQUIREMENTS.—An individual described in clause (ii) meets the independence requirements of this clause if—

''(I) the individual is not affiliated with any related party,

''(II) any compensation received by such individual in connection with the binding arbitration procedure is reasonable and not contingent on any decision rendered by the individual,

''(III) under the terms of the plan, the plan has no recourse against the individual or entity in connection with the binding arbitration procedure, and

''(IV) the individual does not otherwise have a conflict of interest with a related party as determined under such regulations as the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (iii), the term 'related party' means—

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

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

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

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

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

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

''(D) DECISIONS.—

''(i) IN GENERAL.—Decisions rendered by the arbitration panel shall be binding on all parties to the arbitration and shall be enforcible under section 502 as if the terms of the decision were the terms of the plan, except that the court may vacate any award made pursuant to the arbitration for any cause described in paragraph (1), (2), (3), (4), or (5) of section 10(a) of title 9, United States Code.

''(ii) ALLOWABLE REMEDIES.—The remedies which may be implemented by the arbitration panel shall consist of those remedies which would be available in an action timely commenced by a participant or beneficiary under section 502 after exhaustion of administrative remedies, except that a money award may be made in the arbitration proceedings in any amount not to exceed 3 times the maximum amount of damages that would be allowable in such case in an action described in section 502(n).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to adverse coverage decisions initially rendered by group health plans on or after the date of the enactment of this Act.

TITLE III— AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

SEC. 301. APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.

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

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

''Sec. 9813. Standard relating to chapter 101.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO CHAPTER 101.

''A group health plan shall comply with the requirements of chapter 101 and such requirements shall be deemed to be incorporated into this section.''.

SEC. 302. IMPROVING MANAGED CARE.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

''CHAPTER 101—IMPROVING MANAGED CARE

''Subchapter A. Access to care.

''Subchapter B. Access to information.

''Subchapter C. Protecting the doctor-patient relationship.

''Subchapter D. Definitions.

''Subchapter A—Access to Care

''Sec. 9901. Choice of health care professional.

''Sec. 9902. Access to emergency care.

''Sec. 9903. Access to specialty care.

''Sec. 9904. Access to obstetrical and gynecological care.

''Sec. 9905. Access to pediatric care.

''Sec. 9906. Continuity of care.

''Sec. 9907. Network adequacy.

''Sec. 9908. Access to experimental or investigational prescription drugs.

''Sec. 9909. Coverage for individuals participating in approved cancer clinical trials.

''SEC. 9901. CHOICE OF HEALTH CARE PROFESSIONAL.

''(a) PRIMARY CARE.—If a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan shall permit each participant and beneficiary to designate any participating primary care provider who is available to accept such individual.

''(b) SPECIALISTS.—A group health plan shall permit each participant or beneficiary to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

''SEC. 9902. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital, the plan shall cover emergency services (as defined in paragraph (2)(B))—

''(A) without the need for any prior authorization determination;

''(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

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

''(i) by a nonparticipating health care provider with or without prior authorization, or

''(ii) by a participating health care provider without prior authorization,

the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

''(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means—

''(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

''(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

''(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

''(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

''(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care professional and to the extent necessary to stabilize the neonate.

''(C) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

''(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan shall provide for reimbursement with respect to such services provided to a participant or beneficiary other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan provides any benefits with respect to ambulance services and emergency services, the plan shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

''(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term 'emergency ambulance services' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

''SEC. 9903. ACCESS TO SPECIALTY CARE.

''(a) SPECIALTY CARE FOR COVERED SERVICES.—

''(1) IN GENERAL.—If—

''(A) an individual is a participant or beneficiary under a group health plan,

''(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

''(C) benefits for such treatment or services are provided under the plan,

the plan shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 9907) to provide the treatment for such condition or disease or to provide such services.

''(2) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality

care in treating the condition or to provide physician pathology services.

''(3) CARE UNDER REFERRAL.—A group health plan may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

''(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

''(B) in accordance with applicable quality assurance and utilization review standards of the plan.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

''(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan shall provide the individual the option of at least three nonparticipating specialists.

''(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

''(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

''(1) IN GENERAL.—A group health plan shall have a procedure by which an individual who is a participant or beneficiary and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan shall refer the individual to such specialist.

''(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

''(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing special condition' means a condition or disease that—

''(A) is life-threatening, degenerative, or disabling, and

''(B) requires specialized medical care over a prolonged period of time.

''(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant or beneficiary and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

''(c) STANDING REFERRALS.—

''(1) IN GENERAL.—A group health plan shall have a procedure by which an individual who is a participant or beneficiary and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan, or if the primary care provider in consultation with the medical director of the plan and the specialist (if any), determines that such a standing referral is appropriate, the plan shall make such a referral to such a specialist if the individual so desires.

''(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

''SEC. 9904. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—If a group health plan requires or provides for a participant or beneficiary to designate a participating primary care health care professional, the plan—

''(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for covered gynecological care (including preventive women's health examinations) or for covered pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in gynecology or obstetrics, respectively, to the extent such care is otherwise covered; and

''(2) shall treat the ordering of other gynecological or obstetrical care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

''(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetrical care;

''(2) preclude the group health plan involved from requiring that the gynecologist or obstetrician notify the primary care health care professional or the plan of treatment decisions; or

''(3) prevent a plan from offering, in addition to physicians described in subsection (a)(1), non-physician health care professionals who are trained and experienced in gynecology or obstetrics.

''SEC. 9905. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan requires or provides for a participant or beneficiary to designate a participating primary care provider for a child of such individual, the plan shall permit the individual to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

''(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

''SEC. 9906. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant or beneficiary in the plan is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

''(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) DEFINITIONS.—For purposes of this section:

''(A) ONGOING SPECIAL CONDITION.—The term 'ongoing special condition' has the meaning given such term in section 9903(b)(3), and also includes pregnancy.

''(B) TERMINATION.—The term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

''(3) PREGNANCY.—If—

''(A) a participant or beneficiary was determined to be pregnant at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

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

''SEC. 9907. NETWORK ADEQUACY.

''(a) REQUIREMENT.—A group health plan shall meet such standards for network adequacy as are established by law pursuant to this section.

''(b) DEVELOPMENT OF STANDARDS.—

''(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the 'Panel').

''(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and to ensure that—

''(A) participants and beneficiaries have access to a sufficient number, mix, and distribution of health care professionals and providers; and

''(B) covered items and services are available and accessible to each participant and beneficiary—

''(i) in the service area of the plan;

''(ii) at a variety of sites of service;

''(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

''(iv) with reasonable proximity to the residences or workplaces of participants and beneficiaries; and

''(v) in a manner that takes into account the diverse needs of such individuals and reasonably assures continuity of care.

''(c) MEMBERSHIP.—

''(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Representatives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

''(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

''(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

''(d) PROCEDURES.—

''(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

''(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

''(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

''(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

''(e) ADMINISTRATION.—

''(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

''(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

''(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

''(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

''SEC. 9908. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

''No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

''SEC. 9909. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan provides coverage to a qualified individual (as defined in subsection (b)), the plan—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) ROUTINE PATIENT CARE COSTS.—For purposes of this section—

''(A) IN GENERAL.—The term 'routine patient care costs' includes the costs associated with the provision of items and services that—

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

''(ii) are furnished according to the protocol of an approved clinical trial program.

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

''(i) an investigational drug or device, unless the Secretary has authorized the manufacturer of such drug or device to charge for such drug or device; or

''(ii) any item or service supplied without charge by the sponsor of the approved clinical trial program.

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

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

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable items or services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved by an Institutional Review Board.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of the Employee Retirement Income Security Act of 1974.

''Subchapter B—Access to Information

''Sec. 9911. Patient access to information.

''SEC. 9911. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—A group health plan shall—

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

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

''(3) upon request, make available to participants and beneficiaries, the Secretary, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

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

''(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan shall be provided to a participant or beneficiary free of charge at least once a year and includes the following:

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

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

''(A) those that are covered benefits ''(all of which shall be referred to by such relevant CPT and DRG codes as are available), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (all of which shall be referred to by such relevant CPT and DRG codes as are available);

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

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

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

''(E) process for determining experimental coverage; and

''(F) use of a prescription drug formulary.

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

''(A) The number, mix, and distribution of providers under the plan.

''(B) Out-of-network coverage (if any) provided by the plan.

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

''(D) The procedures for participants and beneficiaries to select, access, and change participating primary and specialty providers.

''(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

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

''(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 9901(b)(2).

''(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

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

''(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(B) the process and procedures of the plan for obtaining emergency services; and

''(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

''(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals.

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

''(A) the preemption that applies under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) to certain actions arising out of the provision of health benefits; and

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

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

''(10) INFORMATION ON TREATMENT AUTHORIZATION.—Notice of appropriate mailing addresses and telephone numbers to be used by participants and beneficiaries in seeking information or authorization for treatment.

''(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

''(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

''(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program maintained by the plan.

''(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

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

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

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

''Subchapter C—Protecting the Doctor-Patient Relationship

''Sec. 9921. Prohibition of interference with certain medical communications.

''Sec. 9922. Prohibition of discrimination against providers based on licensure.

''Sec. 9923. Prohibition against improper incentive arrangements.

''Sec. 9924. Payment of clean claims.

''SEC. 9921. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

''(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

''SEC. 9922. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

''(1) as requiring the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan;

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

''(3) as requiring a plan that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan; or

''(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

"SEC. 9923. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

''(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the Secretary of the Treasury, a group health plan, and a participant or beneficiary with the plan, respectively.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

"SEC. 9924. PAYMENT OF CLEAN CLAIMS.

''A group health plan shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant or beneficiary with respect to benefits covered by the plan, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant or beneficiary as well as claims referred to in such subparagraph.

"Subchapter D—Definitions

''Sec. 9931. Definitions.

''Sec. 9933. Exclusions.

''Sec. 9933. Coverage of limited scope plans.

''Sec. 9934. Regulations; coordination; application under different laws.

"SEC. 9931. DEFINITIONS.

For purposes of this chapter—

''(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 9831 shall apply for purposes of this chapter in the same manner as they apply for purposes of chapter 100.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this chapter:

''(1) CLINICAL PEER.—The term 'clinical peer' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

''(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal, or

''(B) is trained and experienced in managing such condition, procedure, or treatment,

and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

''(4) NETWORK.—The term 'network' means, with respect to a group health plan, the participating health care professionals and providers through whom the plan provides health care items and services to participants or beneficiaries.

''(5) NONPARTICIPATING.—The term 'nonparticipating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that is not a participating health care provider with respect to such items and services.

''(6) PARTICIPATING.—The term 'participating' means, with respect to a health care provider that provides health care items and services to a participant or beneficiary under group health plan, a health care provider that furnishes such items and services under a contract or other arrangement with the plan.

''(7) PHYSICIAN.—The term 'physician' means an allopathic or osteopathic physician.

''(8) PRACTICING PHYSICIAN.—The term 'practicing physician' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

''(9) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a group health plan for the provision or coverage of medical services.

"SEC. 9932. EXCLUSIONS.

''(a) NO BENEFIT REQUIREMENTS.—Nothing in this chapter shall be construed to require a group health plan to provide specific benefits under the terms of such plan, other than those provided under the terms of such plan.

''(b) EXCLUSION FOR FEE-FOR-SERVICE COVERAGE.—

''(1) GROUP HEALTH PLANS.—The provisions of sections 9901 through 9911 shall not apply to a group health plan if the only coverage offered under the plan is fee-for-service coverage (as defined in paragraph (2)).

''(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term 'fee-for-service coverage' means coverage under a group health plan that—

''(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

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

''(C) allows access to any provider that is lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan; and

''(D) for which the plan does not require prior authorization before providing for any health care services.

"SEC. 9933. COVERAGE OF LIMITED SCOPE PLANS.

''Only for purposes of applying the requirements of this chapter under section 9813, section 9832(c)(2)(A) shall be deemed not to apply.

"SEC. 9934. REGULATIONS.

''The Secretary of the Treasury shall issue such regulations as may be necessary or appropriate to carry out this chapter under section 9813. The Secretary may promulgate such regulations in the form of interim final rules as may be necessary to carry out this chapter in a timely manner.''.

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle K of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''CHAPTER 101. Improving managed care.''

TITLE IV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 401. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by title I (other than section 102), sections 201 and 202, and title III shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2000 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by title I (other than section 102), sections 201 and 202, and title III shall not apply to plan years beginning before the later of—

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

(B) the general effective date.

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

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 102 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

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

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

(B) require such plans or issuers to—

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

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

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

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

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

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

SEC. 402. COORDINATION IN IMPLEMENTATION.

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

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which both Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

TITLE V—OTHER PROVISIONS

Subtitle A—Protection of Information

SEC. 501. PROTECTION FOR CERTAIN INFORMATION.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discover, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) ACCREDITING BODY.—The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) HEALTH CARE RESPONSE INFORMATION.—The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for the purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) STATE.—The term ''State'' includes a State, the District of Columbia, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(d) EFFECTIVE DATE.—The provisions of this section are effective on the date of the enactment of this Act.

Subtitle B—Other Matters

SEC. 511. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services, in consultation with the Majority Leader of the Senate and the Speaker of the House of Representatives, shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting its the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

The CHAIRMAN. Pursuant to House Resolution 323, the gentleman from Florida (Mr. GOSS) and the gentleman from Michigan (Mr. DINGELL) will each control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. GOSS).

Mr. GOSS. Mr. Chairman, I yield myself 1½ minutes.

Mr. Chairman, I am honored to offer this substitute along with the gentleman from Arizona (Mr. SHADEGG), the gentleman from Oklahoma (Mr. COBURN), the gentleman from California (Mr. THOMAS), the gentleman from Pennsylvania (Mr. GREENWOOD), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Kentucky (Mr. FLETCHER), and a host of other Members.

A few months ago the Speaker asked me to bring all of the voices and viewpoints on this issue together and craft a consensus bill that was sound public policy and not just another sound bite. It is clear that the Norwood-Dingell approach, while crafted with good intention, falls far short of sound public policy because it invites an avalanche of lawsuits and unlimited, uncontrollable damages. This is unacceptably costly, disruptive, and hardly good medicine for anyone, except maybe the trial bar.

Where Norwood is excessive, our substitute firmly stands on responsible middle ground. We hold all health plans accountable. I repeat, we hold all health plans accountable. Patients who have been harmed can sue and recover damages. Instead of guaranteeing lawsuits at the front end, we encourage patients to get the health care they need first.

Some have commented about special interest endorsements in this process, about the various proposals before us today. I am told that over 100 patient and provider groups have endorsed our substitute amendment, but no, repeat,

no trial lawyer groups or insurance associations have. I therefore suggest we have struck the right balance, and urge Members' support accordingly.

Mr. DINGELL. Mr. Chairman, I yield myself 1½ minutes.

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

Mr. DINGELL. Mr. Chairman, the advocates of the substitute here, for whom I have enormous respect and affection, are going to talk about only one thing this morning, trial lawyers. Let us talk about the other things that are important, because other issues are being ignored by them.

Our bill, the Norwood-Dingell-Ganske bill, guarantees that your health plan will give you the prescription medicines you need. Theirs does not.

Our bill guarantees that you will be able to get into an approved clinical trial if you are threatened with serious diseases such as multiple sclerosis, Alzheimer's or Parkinson's. Theirs does not.

Our bill guarantees that the doctor can be an advocate for a patient, through internal and external appeal of a plan's decision, without any fear of being terminated by the HMO. Their doctor has no such assurance.

Their bill allows the HMO to punish your doctor. Our bill guarantees that you will be told when your insurance company offers rewards to health care providers for not providing you with a specialist or giving you cheaper but less effective treatment.

Their bill allows HMOs to keep you in the dark. Our bill allows none of these things.

These are not the only real differences between the substitutes. Others will be addressed in further detail by different participants in the debate.

In the end, the bill offered by my good friends, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG), for whom again I repeat I have great respect and affection, is no substitute whatsoever for real managed care reform.

Give managed care reform that protects the patient, that protects the doctor, that sees to it that medical necessity is dealt with by the doctor, and that the rights of the patient are assured.

Mr. GOSS. Mr. Chairman, I am pleased to yield 5 minutes to the distinguished gentleman from Arizona (Mr. SHADEGG), a principal author of this substitute.

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

Mr. SHADEGG. Mr. Chairman, I am passionate about this issue. For the last 2 years, I have done almost nothing else. I believe this is a momentous debate. But I am greatly offended by what is going on on the floor. The truth is that there are two extreme positions here, and there is a lot of misrepresentation going on.

Some of the most serious misrepresentation that is going on is the allegation that Republicans do not care about patients and that the Coburn-Shadegg bill will not protect them. I am enraged by that comment.

There is not a Member of this House, not one, Republican or Democrat, man or woman, not the gentleman from Georgia (Mr. NORWOOD), not the gentleman from Iowa (Mr. GANSKE), not the gentleman from Michigan (Mr. DINGELL), who is more passionate that HMOs must be held liable when they kill or maim someone. No one. No one beats me on that issue.

I have written a series of ''dear colleagues,'' which you all should have read, and given them to the press, and it says, point blank, ERISA abuses people. Courts cry out for reform. It is quote after quote after quote from Federal judges describing that absolute immunity is wrong. And from my conservative friends I have been beaten up because I am not sufficiently pro-business.

But let me say that the gentleman from Georgia (Mr. NORWOOD), whom I love and respect, is wrong, because the gentleman from Georgia (Mr. NORWOOD) said the only bill that can become law is a bipartisan bill, and he would be right if yours were a bipartisan bill. But it is not a bipartisan bill, because just as immunity is extreme and wrong and bad public policy, so is outright, absolute, total liability.

The sad truth is that in the gentleman's to change the law, and in his decision to throw in with the other side, including the President, this issue became political, and not about patients. It needs to be about patients.

The reality is no bill we pass here on the floor can, in fact, become law if it is so extreme that it results in employers being sued; and the gentleman's provision to protect employers fails.

Now, I know that the gentleman from Georgia intended to write it to protect employers, but it does not do that. If they use simple discretionary authority, they can be sued.

I also know that the gentleman did not want and may not have intended to throw the door open to wide open liability so that one can sue anyone, anywhere, any time, for everything. But that is the way the bill is written. The gentleman's bill will result in handing the entire process over to the trial lawyers. That will never become law.

What we need is a middle ground which holds plans accountable, says you can no longer kill and maim people the way United Health Care did in United Health Care versus Corcoran, killing Mrs. Corcoran's baby. But we also need a law that says we are not going to turn the entire system over to the tort lawyers and let the tort lawyers get rich and buy Cadillacs and Lexuses and other cars out of the winnings of this system, driving people away from health care.

If American businesses walk away from insuring America's workers, we have not helped the system. We need a reasonable middle ground. We do not need one extreme immunity or another extreme turning the system over to the trial lawyers.

Now, I know you are well intended, but the sad truth, contrary to the description of the gentleman from Michigan (Mr. DINGELL), is that your bill goes too far. It can never be law.

I want a law that protects American people, that gives them health care. Employees working for American businesses need health care, and giving the system to the trial lawyers will not do that, any more than giving the system to the greed of the trial lawyers. Greed by insurance company fails. Greed by trial lawyers fails.

We need a middle ground system. We need desperately to pass a bill that strikes a fair balance, that says no, you do not get immunity, you cannot injure and kill people and, no, we are not going to give the whole system over to the trial lawyers. We are going to require people to take reasonable steps, and we are not going to let the trial lawyers ring the bell and get multimillion dollar judgments and have that come out of all of our pockets and have it drive Americans away from health care. Tick through your liability provision; tick through your employer protections. You may have intended them to work, but they do not.

In this debate it has been said that the truth has been lost. It is alleged that we have preempted State law. There is no one in this Congress that is more States rights than JOHN SHADEGG. We have not preempted State law. We have specifically said that Texas, Georgia, Louisiana, and any other State which passes a law to protect its patients may do so, and that law remains in effect.

I implore you to pass the Coburn-Shadegg substitute.

Mr. DINGELL. Mr. Chairman, I am happy to yield 4 minutes to the gentleman from Georgia (Mr. NORWOOD), my friend that I have come to respect and admire greatly.

Mr. NORWOOD. Mr. Chairman, I thank the gentleman for yielding me time.

Mr. Chairman, let me start by saying I agree with the gentleman from Arizona (Mr. SHADEGG), my good friend, that he really does, I believe, sincerely want to try to protect patients; and he really does think that he is in the middle.

□ 1300

We dealt earlier with one bill that absolutely does not at all, and we are dealing with their bill that does not, in some respects either, and my view is that we are in the middle.

I have listened to all of my colleagues make the argument that they protect businesses and that we do not. I have listened to my colleagues take on the use of the term discretionary authority and how by using direct participation, my colleague's bill protects employers so much better. But when

we look at the terms very closely, we see, really, that there are not really any differences.

We protect an employer from liability for their choice of plan and any benefits they put in their plan. They protect an employer from liability for their choice of plan and any benefits they put in their plan. Notice, the same thing. We protect an employer who provides an extra contractual benefit that is not in a plan. My colleagues protect an employer who provides an extra contractual benefit that is not in the plan. Notice we are saying the same things. We protect an employer who does not intervene in a review. My colleagues protect an employer who does not intervene in a review. Notice, I am repeating myself. But my colleagues want to go further. My colleagues want to protect an employer who advocates for a patient.

Now, I would not disagree, and I would argue that our bill does not make an employer liable who advocates for a patient, unless by advocating my colleagues mean an employer can get in and settle a dispute by making a medical decision about what coverage is appropriate, what coverage is medically needed. If that is what my colleagues mean by advocate, then I am not going to support that. But the bottom line is our efforts to protect employers really say the same thing.

Our bill does not authorize any cause of action against an employer, plan sponsor, or employee. That will be the new Federal law that goes into ERISA. In our bill, there is no right of recovery by a person against an employer, plan sponsor, or employee for damages.

Now, we go on further to say, there is one exception. In our bill we simply say, one can be liable for a cause of action against an employer, plan sponsor or employee if, if, any of the above exercise their discretionary authority to make a decision on a claim that is a benefit in the plan covered by the plan, and that decision results in personal injury or wrongful death.

I do not know how to say that any clearer. Discretionary authority simply means that the employer has the power to make a decision. One can make a decision in our bill to give an employee a benefit that maybe is not in the plan. The new Federal law will say, one is not liable if one wishes to do that. It is clear as a bell. Look on page 99.

We further protect employers by allowing the employer to put in what they want in the plan and what they do not want in the plan. If they want to exclude hospitalization, that is not my business. They can exclude hospitalization in the plan that they buy. The new Federal law will make certain that they are not liable because they did that.

One is not liable in our bill for not being involved in external review. My word, it is so very narrow. It simply says if the CEO, and it is much like the Thomas bill in the protections that it gives. We simply say, if the CEO really wants to get in there and make a medical necessity decision that takes away a benefit that is a benefit in the claim and the patient dies, one needs to be liable.

Mr. GOSS. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from the Commonwealth of Pennsylvania (Mr. GREENWOOD), a principal author also.

Mr. GREENWOOD. Mr. Chairman, I thank the gentleman for yielding me this time.

Last weekend I went to the Doylestown Township Octoberfest, and I was talking to some of my constituents, and a gentleman came up to me and he said, tell me that it is not true that you guys in Washington are getting ready to pass a bill that would allow me to get sued because I provide insurance coverage to my employees; and I said well, we are going to have that debate, and I am going to go down there and try to protect you from that consequence.

I am not a lawyer, and I have listened to the debate go back and forth between the lawyers and nonlawyers and doctors and so forth. But here is what common sense tells me. Common sense tells me that under the Norwood-Dingell bill, employers will get dragged into court. Now, not in all cases will they be found liable, but they will get dragged into court, because someone will make an allegation that they were harmed; someone will make an allegation that the employer exercised discretionary authority, and there is the employer, the small employer, sitting in a courtroom. And the first time we drag an employer into a courtroom is the last time that employer is going to provide health care coverage for his employees, because it is not worth it. He does not want to get dragged into a courtroom for trying to provide a benefit for his employees.

This is obviously a balancing act. It has been said over and over again, but this is a balancing act between too little liability and too much liability. The Goss-Coburn-Shadegg-Greenwood-Thomas, et cetera, coalition product is the middle ground. It is the exact right, in my opinion, balance between these two extremes.

I bet my colleagues, if the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) were sitting here at the dawn of the creation of malpractice liability, they would be about where we are, at best. They would be in the middle. They would be trying to design a system that leaves doctors accountable for this negligence, but not exposed to the maelstrom of liability cases that they are exposed to today.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Texas (Mr. GREEN).

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

Mr. GREEN of Texas. Mr. Chairman, I thank my colleague, the ranking member of the Committee on Commerce, for yielding me this time.

I am glad to follow my colleague from Pennsylvania, because I do not know if I would call their amendment anywhere near middle ground. It may be middle ground from that side of the aisle, but it is not middle ground between the two aisles, and that is what the Norwood-Dingell-Ganske amendment does. The middle ground is really the amendment that is the base of this bill.

The Coburn-Shadegg proposal falls short of meeting the needs of the American people in the most critical issue: accountability. Unlike the Norwood-Dingell-Ganske, the amendment we are considering now will force patients harmed by their HMOs to seek remedies in Federal court. The practical effect of the Federal court provision would be devastating for patients.

First, the Federal court system is more difficult to access than our State courts. People have to travel longer distances, particularly in large States or rural areas. Worse yet, in Federal courts, Federal courts give priority to criminal cases. I know in Texas we have civil courts, we have State civil courts, we have county civil courts; but the Federal courts have to give preference to criminal cases. So these cases will sit behind them.

The Norwood-Dingell-Ganske builds on the success of our State's efforts, the State of Texas, both rural, urban, rich and poor and great diversity, and we need to learn by example.

One of the concerns I have about the amendment, Coburn-Shadegg-Greenwood, et al., is that it would actually overturn current laws that we have. Not only in my home State of Texas, but Missouri, Georgia, and California already have laws in effect to protect their citizens against negligent HMOs. In plain English, no State law can protect its citizens when HMO's medical decisions causes harm or death, and that is what Coburn-Shadegg says, and it is the section of the bill. They are preempting State law that our States have used. The State of Texas has had it for 2 years now, and it has stood the test of time. We have only had three court cases filed, but what we found out because of the effectiveness of the appeals process and, ultimately, judicial accountability, that is why we only have three cases filed, the appeals panel is working. They are finding for the patients over half the time, and that is why we need to make sure that we will not be faked out or pass a false amendment. The Coburn-Shadegg amendment is not a compromise; it may be a compromise on one side of the aisle.

Mr. GOSS. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Louisiana (Mr. COOKSEY) who has assisted me mightily from his medical professional point of view.

Mr. COOKSEY. Mr. Chairman, I want to address the American people and the patients.

Since I have been in Washington, I find that there are a lot of groups out there that are looking out for themselves. There is big insurance, and they have overstepped the bounds. HMOs have ridden behind ERISA and overstepped their bounds, and they are guilty as charged. The trial lawyers are here and have been here at least for the last 7 years getting their message out, and they all spread a lot of money. And yes, the physicians are represented with their organizations, and I am a member of that profession and a member of those organizations.

But too often I get the feeling that there is no one here really representing the patients, the public; and that is what we really need to do today. We need to address the excesses of the HMOs. But at the same time, we do not need to open this up to unlimited litigation, because litigation is not going to improve the quality of health care, and that is what the issue is about. It is access to health care and quality of health care. That is the reason I am supporting this bill.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I rise in strong opposition to this amendment. This amendment provides the illusion of accountability, but there is a serious flaw blocking the right of people to get to the courts, and that flaw has to do with apparently the unilateral right of managed care industries to refer findings of fact and conclusions of law on whether there was substantial harm and whether that substantial harm was proximately caused by the decisions of the managed care plans to a private, corporate, nonjudicial body, which can act in an ex parte way; which can act in a way without regard to the Rules of Procedure or evidence.

Mr. Chairman, I include a letter from Dean Rand Rosenblatt of Rutgers Law School and Professor Rosenbaum of George Washington University which outlines these concerns.

THE GEORGE WASHINGTON UNIVERSITY,
Washington, DC, October 6, 1999.

Re: Analysis of the amendment in the nature of a substitute, to be offered by Mr. Coburn to H.R. 2723, The Health Care Quality and Choice Act of 1999.

Hon. JOHN DINGELL,
Ranking Member, Committee on Commerce, U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE DINGELL: This letter responds to your request for a legal analysis of the amendment that Mr. Coburn will offer to H.R. 2723 (hereinafter referred to as the Coburn amendment).

The Coburn amendment purports to add a federal remedy to the current range of judicial remedies under both ERISA and state law in cases involving patient injury. In fact, however, the amendment appears to be a legislative attempt to preempt all available medical malpractice remedies under state law as applied to managed care companies. In other words, the amendment appears to give companies a complete shield against any further medical malpractice cases under state law in which they would be a named defendant. As such, this amendment, which to the best of my knowledge has received no careful analysis and has not been subject to any prior debate, appears to reverse the leading case in the field, Dukes versus U.S. Healthcare Inc.

this federal legislative attempt to sweep away two centuries of state malpractice law in favor of a new and untested federal remedy appears to fly directly in the face of recent Supreme Court decisions regarding the limitations of Congressional authority to displace state law in areas historically committed to the powers of the states. The creation of remedies for personal injuries is the epitome of historic state powers to protect the health and welfare of their citizens.

Finally, close scrutiny of the ''remedy'' created in the Coburn amendment so tips the scales in favor of managed care companies that the amendment, even if not an unconstitutional exercise of Congressional powers in an area of law reserved to the states, may violate basic principles of constitutional due process.

Our analysis follows.

The amendment appears to preempt all state law remedies for medical malpractice cases involving managed care companies.

Section 502(n)(15) as added by the Coburn amendment purports to ''save'' malpractice remedies available under state law. However, the amendment is very carefully worded to limit the types of actions that would in fact be ''saved:''

Protection of medical malpractice and similar actions under state law—This subsection shall not be construed to preclude any action under State law * * * not otherwise preempted under this title with respect to the duty (if any) under state law imposed on any person to exercise a specified standard of care when making a health care treatment decision in any case in which medical services are provided by such person, or in any case in which such decision affects the quality of care or treatment provided or received.

At first blush, the amendment appears to save both actions aimed at persons who provide medical care as well as persons who make decisions that affect the quality of the care. But a closer look reveals that these actions are saved only to the extent that they are ''not otherwise preempted under this title.'' In fact, the new federal remedy is squarely aimed at persons whose decisions affect the quality of care. Specifically, the remedy would allow a right of action against substandard decision making by health benefit plan fiduciaries. It is their failure to ''exercise ordinary care in making an incorrect determination'' regarding the medical necessity or availability of a treatment that would be the subject of the new federal remedy. As a result, this new remedy would appear to preempt existing remedies grounded in state malpractice theory, that are aimed at the companies themselves.

This attempt to preempt the application of medical malpractice principles to managed care companies should come as no surprise. This is a critical juncture in the development of judicial theory regarding the conduct of managed care companies. In recent years, a growing number of courts have specifically have held that under various theories of direct and vicarious liability, managed care companies themselves—not just the doctors who work for them—can be liable for injuries caused by substandard decisions that affect the quality of care. These courts have distinguished for ERISA preemption purposes between state law-governed actions for damages as a result of injuries arising out of negligent coverage decisions (which are preempted) and state law actions alleging injuries as a result of the poor quality of medical care (which are not).

By appearing to ''save'' malpractice actions while at the same time creating a new federal right of action for injuries caused by substandard treatment decisions made by fiduciaries, the amendment thus appears to reverse these recent decisions and shields companies from the effects of state law.

The amendment appears to violate recent Supreme Court decisions regarding the limits of Congressional authority to legislate in areas historically left to the powers of the states.

The process envisioned in the new federal remedy appears to run headlong into the Constitution. There are so many deficiencies in the procedures set forth in the amendment that it is impossible to enumerate all of them. Most fundamentally in our view, the amendment appears to give defendants (e.g., health plans and health insurance issuers) the right to seek an ex parte determination from any qualified external appeal entity regarding whether the plaintiff actually sustained a personal injury, and/or whether the defendant's conduct was the proximate cause of the injury. Giving a private corporation the power to halt a federal judicial action through the use of non-judicial procedures, and with no statutory requirement of notice to the plaintiff or other due process rights, is unprecedented in American civil law.

The provisions of the amendment are simply extraordinary. The bill provides that even after an individual has exhausted the internal and external review process and filed an action in federal court, a managed care company is empowered to nullify the jurisdiction of that court by unilaterally deciding that the action will be heard before a private entity with no clearly relevant legal expertise and with no provision for a right to counsel, a jury trial or any other due process protections for the plaintiff.

Private companies would have the power to obtain a definitive ruling against patients without patients ever having the opportunity to be heard before the entity making the certification decision. And a federal court with Constitutional authority to hear a case would be stripped of its Constitutional authority and directed to dismiss the case with prejudice based on a ruling by a non-judicial entity.

Nothing in the bill would prohibit a defendant from consulting entity after entity until it finds one that will decide in its favor. Fundamental questions of fact and law would be definitively determined by employees of an external review entity who could theoretically consist entirely of physicians with no judicial training. The measure grants neither discovery nor cross examination rights as part of the certification procedure.

Moreover, unlike a jury, employees of the external review entity would make critical findings of fact, not pursuant to a set of instructions from a legally trained and constitutionally impartial judge, but based on their own legally unguided impressions.

Finally, these findings of fact would not be subject to challenge or appeal by a judicial body, but rather would become legally binding in all judicial venues. Under the amendment, it appears that even the United States Supreme Court could not overturn the certification of an external review entity that the cause of the plaintiff's injury was not the negligence of the defendant.

Between the apparent ex parte nature of the certification process and the granting of

sweeping judicial powers to private medical review bodies, the bill violates all notions of Constitutional due process.

Apart from its basic Constitutional problems, the right of action created by the bill contains additional serious shortcomings. The measure permits actions only against persons who have the authority to make the final determination of coverage. Such a provision could shield from liability a utilization review company under subcontract to the managed care organization, thereby undercutting any incentive to ensure better utilization review procedures.

Furthermore, the bill would condition the new right of action on exhaustion of the internal and external review process even when the injury already has occurred and exhaustion is futile. This rigid requirement is contrary to current law, which permits individuals to proceed directly to court under ERISA §502 in situations in which exhaustion would serve no purpose.

Furthermore, in cases in which a plaintiff has commenced both an action for damages under state law, as well as an action under this new federal remedy, the commencement of the federal action would immediately supercede ''any action authorized under state law'' against any person based on the same substantial harm.'' Section 502(n)(16)(B), as added. In other words, even if the amendment does not completely preempt actions against managed care companies that are grounded in state malpractice theory, it would effectively halt malpractice actions once an action under this new federal remedy is filed.

Not only does the filing of a federal action stop a state malpractice action, but the resolution of the federal case would fundamentally determine the course of the state case, as well. Under normal principles of collateral estoppel, when faced with a successful affirmative defense to the new federal right of action, a court with a malpractice action before it that turns on the same facts would inevitably dismiss the malpractice action.

Rather than allowing state law regarding malpractice liability in managed care to evolve, the bill would impose a radical, unnecessary, and untested remedy on state governments in an area traditionally committed to state discretion.

The question of when and under what circumstances insurers' liability for damages arising from negligent coverage decisions should be recognized under the law is a complex matter.

State courts began to address this issue in the early 1970s and the theory of insurer liability has slowly evolved. The application of ERIS to liability claims against insurers that sold products to employee benefit plans seriously affected the application of such laws to injured employees. In recent years, as ERISA preemption law has been refined and narrowed by the courts, states once again have begun to carefully approach this issue in the context of employee benefits.

In our view, this is not the time to create a new federal remedy, especially one as controversial as this. In light of the evolutionary nature of American health law, and the limits on Constitutional authority to displace state law, we believe that it is far more advisable to permit states to move the matter forward through legislation that best meets the needs of the residents of their states, particularly since the evidence to date indicates that the growth of such state laws has not resulted in either major cost increases in health insurance or a withdrawal of insurers from the market.

Sincerely,

SARA ROSENBAUM,
Harold and Jane Hirsh Professor of Health Law and Policy, The George Washington University Medical Center, School of Public Health and Health Services.

RAND ROSENBLATT,
Associate Dean for Academic Affairs and Professor of Law, Rutgers University Law School—Camden.

Mr. ANDREWS. Mr. Chairman, I believe that these are more than technical flaws. I believe they are substantive blockages which preclude the right of people to pursue remedies in the Federal courts. For these reasons, I strongly oppose the amendment.

Mr. GOSS. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Louisiana (Mr. VITTER), who I believe is not only one of the freshest new Members, but is the freshest new Member from Louisiana on the Republican side.

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

Mr. VITTER. Mr. Chairman, I rise today as an original cosponsor of a strong bill to provide patient protection, and I rise in support of this version in particular, because many of its provisions are the strongest available on the very patient protection issues we care about.

This version goes further than any other proposal in granting access to hospital emergency rooms and ambulance services, and in ensuring that women have hassle-free access to OB/GYNs. It goes further by providing a quicker independent review process and fully protecting employers from lawsuits while allowing patients the right to sue their HMO.

So this very version, in my opinion, goes further on so many important fronts on the patient protection issue, even leaving the liability debate to the side.

Mr. Chairman, many would rather create partisan issues or enrich the coffers of trial lawyers than provide meaningful protections, the strongest available, to patients. Let us stop the political gamesmanship and pass strong patient protection.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Missouri (Ms. MCCARTHY).

(Ms. MCCARTHY of Missouri asked and was given permission to revise and extend her remarks.)

Ms. MCCARTHY of Missouri. Mr. Chairman, I thank the gentleman from Michigan and rise in opposition to the amendment and in strong support of the bipartisan Norwood-Dingell managed care act.

We have all heard horror stories from our constituents, family members and friends. It is time for real reform. A constituent of mine in a head-on car wreck with massive trauma on his head, a collapsed lung, three broken ribs, and a shattered hip went through numerous surgeries in a struggle to regain the life he had before the accident. He contacted me because he had been denied productive physical therapy from his HMO despite his doctor and orthopedic specialist prescribing the physical therapy.

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Passing the Norwood-Dingell bill will improve patient care at the most fundamental level, and return medical decisions to patients and health care professionals.

This approach is working well at the State level. The current amendment we are considering will wipe out these State laws. I urge my colleagues to oppose the Coburn-Goss-Shadegg amendment and support the Norwood-Dingell bill.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to my good friend, the gentleman from Washington (Mr. BAIRD).

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

Mr. BAIRD. Mr. Chairman, I would like to just raise two simple points. We have heard briefly a minute ago, who is here to represent patients? Well, I am here to represent patients. Prior to coming to serve in the Congress, I worked for 23 years in the mental health field as a licensed clinical psychologist.

Every major health care organization supports the Dingell-Norwood bill, every single one, bar none. If you are going to see a health care provider, be they a doctor, nurse, a clinical psychologist, a social worker, a physical therapist, occupational therapist, you name it, their professional occupation supports Dingell-Norwood. Those same professionals to whom we trust our health care would oppose this poison pill amendment.

As a psychologist, I am particularly concerned about one provision of this bill, the exemption for liability claims when mental health is damaged. I personally had the experience of working with a patient who was suicidal. Twenty-three years of clinical experience said if this patient did not get additional care, they very likely might go out and kill themselves. This bill would exempt insurance companies from liability for mental health damage. That is wrong. We need to support Norwood-Dingell.

Mr. GOSS. Mr. Chairman, I am happy to yield 2¼ minutes to the gentleman from Kentucky (Mr. FLETCHER), who was instrumental in guiding us on some of the provisions of this substitute amendment.

Mr. FLETCHER. Mr. Chairman, I thank the gentleman for yielding time to me. I appreciate the opportunity to address this bill.

I want to give my thanks to the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) for the extensive work they have done on this, coming from a great deal of concern about patients and a great deal of clinical experience in providing care.

Certainly I appreciate my colleagues, the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD), for all the work they have done to bring this debate here to the floor this day.

I am here to support the coalition bill, the Coburn-Shadegg bill, because it is the best bill to provide the patients that I have taken care of real protection. It is real patient protection. It is not real trial lawyer protection, I will grant that. No ambulance chasers are going to be smiling today when we pass this bill.

But patients will, because they will be assured that, first, physicians are making medical decisions, not insurance bureaucrats. Secondly, they will make sure that the cost does not go up so much that they end up with no insurance. Causing patients to lose their health insurance is not patient protection. If anyone has seen what the plight of patients are when they do not have health care, how they deliberate at home as to whether they are going to go to the physician, whether they are going to go to the emergency room, because they know it may result in bankruptcy, you know what it means to a family and patient not to have health insurance.

Yet, I believe this bill, the Norwood-Dingell bill, will drive up health care costs and drive up the number of uninsured. It is very important that we pass this coalition bill.

It is kind of interesting to me. As a physician, my primary concern is patients. It is not the special interest groups, whatever they are. I will say that this bill probably does not please a lot of the special interest groups. I think when we reach a bill that probably is balanced and fair, it really protects patients, primarily.

It is interesting to me that, as a physician, we have cried out for help with tort reform for years. We have said, give us some relief and we can reduce the cost. I talked to an OB–GYN physician just this last week who said, my malpractice insurance has gone up to $40,000 a year. This bill will increase the cost of malpractice. It will increase the cost of health care. That money will go into the pockets of trial lawyers.

That is not what we want to do for the patients. That is not real patient protection. Vote for the Coburn-Shadegg coalition bill, for our patients' sake.

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

Mr. GANSKE. Mr. Chairman, I appreciate the concerns of my fellow physician, the gentleman from Kentucky, particularly on the issue of cost. This is an important issue. We think that the cost to the bipartisan managed care bill will be very small, and that that is part of the reason why Members should support it.

Why is that? The critics of our bill have said that it is going to result in a lot of lawsuits, but if we look at a study that was recently done by Coopers & Lybrand for the Kaiser Family Foundation, where they compared group health plans that do not have a liability shield to those that do, the incidence of lawsuits was in the range of from .3 to 1.4 cases per 100,000 enrollees, and they showed that the legal costs for those group health plans that are not shielded was from 3 to 13 cents per month per employee.

That is a small price to pay for somebody who is spending thousands of dollars for their HMO coverage to be sure that that health plan then will not cut the corners too tight in the pursuit of profits that could result in harm or injury, when under current ERISA law they are shielded from that liability.

Under the plain meaning limits of our bill, the provisions, as looked at by a leading ERISA law firm in the country, have shown that we do exempt employers. It is the plain meaning of our bill. That is part of the reason why the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) put in about 5 or 6 extra pages that are very circular that in the end, basically, in my opinion, and we will go into that in more detail, shield the employer, or rather, shield the health plans, just like the problem we are trying to correct.

Mr. Chairman, we have a chance today to fix a problem that Congress created 25 years ago. The substitute we are debating now just does not do it.

Mr. GOSS. Mr. Chairman, I am pleased to yield 1 minute to the distinguished gentleman from Wisconsin (Mr. GREEN), to demonstrate the broadness of the consensus group that we have.

Mr. GREEN of Wisconsin. Mr. Chairman, I thank the gentleman for yielding time to me.

I would like to draw attention back to one very simple thing. For better or worse, we have an employer-based health care system in this Nation. That is a fact. Some of us would like to change that, but today, as we are standing here, we have an employer-based system. As long as we do, we must reject plans that would lead employers to drop coverage.

The debate over liability, and we are hearing it on both sides as to what that means, the debate over liability shows at the very least that it creates uncertainty for employers. Where they have uncertainty, we know in order to avoid risks they are going to drop coverage.

In Wisconsin, we have the lowest level of uninsureds in the Nation. We understand that we cannot protect patients unless they have health insurance. Unfortunately, unless we pass this amendment, all we are going to do is drive up costs, drive up uninsured levels. We will not have access to care and we will not have patient protection. Please support this amendment.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Tennessee (Mr. FORD).

Mr. FORD. Mr. Chairman, if we listen to the debate, one could become easily confused that it is trial lawyers who are telling patients no, it is trial lawyers who are denying care.

I understand there may be some aversion, there may be some opposition on the other side to the role that trial lawyers play in helping to even the playing field here in America, but they are not the cause or root of this problem.

As a matter of fact, things have gotten so bad that some of my friends on the other side, and I indeed say friends because many of them are, that their own front-runner presidential nominee has suggested that they soften their image, that perhaps they have gone overboard and exceeded the boundaries of fairness and perhaps even compassion, here in this body and in this Nation.

I applaud the leadership that the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Louisiana (Mr. COOKSEY) and others in this body have demonstrated on this issue. But I do think it is important that we put this issue in its proper context. This is just about accountability.

I think there are issues that can be resolved between Coburn-Shadegg and Norwood-Dingell. There are legal issues which some of the lawyers in the Chamber perhaps understand and others do not. But around here, this is just about accountability. HMOs and foreign diplomats are the only people who are above the law. That should end, and we could do it with the Norwood-Dingell bill.

Mr. GOSS. Mr. Chairman, I am happy to yield 1 minute to the distinguished gentleman from the Commonwealth of Pennsylvania (Mr. ENGLISH), who has contributed, as well, to our effort.

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

Mr. ENGLISH. Mr. Chairman, I rise in strong support of the Goss-Coburn-Shadegg substitute. This amendment arguably provides better health care quality standards than the Dingell-Norwood plan and better protection for working families by, among other things, including emergency ambulance services in the prudent lay persons standard for emergency care coverage, to ensure that patients are not worried about calling their insurance company before calling an ambulance; by reducing the time limits in expedited cases from 72 hours to 48 hours; by providing broader access to all cancer clinical trials; by providing for a voluntary alternative dispute resolution system, binding arbitration for those who do not want to go to court; by guaranteeing pathology and laboratory services; by creating a panel to establish network adequacy standards, to

ensure that each plan has enough doctors in specialties for plan participants; by prohibiting plans from considering FDA-approved drugs or medical devices, experimental or investigational; and by protecting employers from indiscriminately being held liable in lawsuits.

Health care access will suffer if employers or even trade unions are exposed to legal liability for providing health care coverage for workers. Goss-Coburn has a commonsense liability provision that holds HMOs responsible, but also caps damages and puts time limits on lawsuits.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Chairman, I rise in opposition to this amendment, which falls short, far short, on important patient protections.

If a patient has been denied a screen test or a treatment which results in a serious health care problem, the HMO must be held accountable. This amendment contains a $100 threshold for patients to be eligible even for external review. Mammograms cost $95. A routine EKG is $50. A PSA for prostate cancer is $25.

As a nurse, I am very concerned that a person who is denied a simple, inexpensive, lifesaving test would never be eligible for that review. The Coburn-Shadegg substitute will diminish fundamental constitutional rights of patients to seek redress in the courts when they have suffered serious physical harm or even been killed. This provision will save HMOs a few dollars and cents, but it defies common sense.

Mr. Chairman, patients must no longer take a back seat to profits. I urge my colleagues to oppose this amendment and to support the Norwood-Dingell bill.

Mr. GOSS. Mr. Chairman, I am pleased to yield 1 minute to a close colleague and friend, the gentleman from Florida (Mr. WELDON), who obviously has been of much assistance in putting on this measure.

Mr. WELDON of Florida. I thank the gentleman for yielding time to me, Mr. Chairman, and I rise in support of the Goss-Coburn-Shadegg substitute.

Mr. Chairman, I came to Washington from my medical practice in 1995, feeling at that time that the managed care industry had placed the bottom line ahead of quality of care, that insurance company and HMO bureaucrats were practicing medicine, and that they needed to be held accountable, as accountable as I was when I practiced medicine.

□ 1330

However, I also felt that our society had become too litigious, that we had too many lawsuits. I believe that this substitute before the body now strikes the right balance between these two conflicting needs. It allows for the maintenance of quality through strong internal and independent external appeals processes, but it still reserves the right of individuals to seek redress in court for their injuries. I feel that it is the piece of legislation that we should be enacting.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from New York (Mrs. MCCARTHY).

(Mrs. MCCARTHY of New York asked and was given permission to revise and extend her remarks.)

Mrs. MCCARTHY of New York. Mr. Chairman, I rise in support of the Bipartisan Consensus Managed Care Improvement Act. I rise today to speak as a Congresswoman from Long Island, a mother, and a nurse.

I spent close to over 30 years as a nurse, and I speak from experience when I remind my colleagues health care is about people. Real health care means direct access to specialists, especially in OB/GYN for women. Real health care means access to emergency room care. Real health care protects health care workers from retaliation from their employers when they blow the whistle on wrongdoing. Real health care saves lives by making clinical trials available to patients, not just cancer patients, but to patients that are suffering from many diseases. Real health care is a clean Norwood-Dingell bill.

The reason is, the first lesson I learned in nursing school was the patient always comes first. I hope we remember that when we vote today.

One other thing that I would just like to bring up very rapidly, 5 years ago, when I was an average citizen and had my health care insurance, I could not sue my HMO. Today, because I work for Congress, I am allowed to sue.

Mr. GOSS. Mr. Chairman, I am privileged to yield 1 minute to the gentlewoman from New York (Mrs. KELLY), a distinguished medical professional and activist.

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

Mrs. KELLY. Mr. Chairman, it is as a professional health care advocate that I rise in support of the Goss-Coburn-Shadegg-Greenwood-Thomas substitute amendment.

This amendment provides patients with vital protections that the Norwood-Dingell bill does not, such as shorter external appeal times, network adequacy standards, access to ambulance services, guaranteed pathology services, and a prohibition on plans labeling FDA approved drugs and devices as ''experimental.''

This amendment ensures patients get the care they need when they need it. It leaves medical decisions up to doctors, not insurers, and not lawyers. It allows doctors to treat their patients and prevents insurers from making medical necessity decisions. Insurers will be held accountable for wrongful actions; and patients, if injured, can go to court to sue for damages.

This substitute amendment also broadens the appeals process a patient may use by allowing binding arbitration as an alternative option to court. Arbitration will provide those patients who choose to select it the opportunity to appeal medical coverage decisions and to hold health insurers financially accountable for wrongful decisions in a nonthreatening forum with the same protections as court, but without the cost and time consumption.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Chairman, the Norwood-Dingell bill protects States' rights to regulate medical malpractice, a right that has existed for over 200 years.

In Texas, we passed patient protection legislation. It is working. There is no reason to conclude that we will run to the courthouse or that there has been a rush of litigation.

This House rejected the Boehner substitute because it allows insurance companies to avoid accountability. But equally damaging is to allow insurance companies to avoid medical malpractice laws of our 50 States by creating an exclusive preemptive Federal cause of action that is nothing more than the insurance company protection act of 1999.

The Coburn substitute blatantly tips the scales of justice in favor of the insurance companies. It privatizes justice by giving a private panel the authority to make judicial findings that are binding on the Federal court. Giving private entities the power to make findings that bind the Federal court is unprecedented in American law, and this provision should be rejected.

This substitute gives legal protection from liability to insurance companies enjoyed by no other group except foreign diplomats. We must protect patients. We must preserve accountability. We must preserve States' rights and reject the Coburn substitute.

Mr. DINGELL. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from Georgia (Mr. NORWOOD), which is going to be a benefit to both the gentleman from Florida (Mr. GOSS) and to myself.

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from Michigan for yielding me this time.

Let me make this very clear. Let me also just thank the gentleman from Oklahoma (Mr. COBURN). I think that his bill has tremendous things in it in terms of patient protections. They have tried very hard. He and I have worked together for months and months and months.

But the problem is, and I will try to get through some of them at this point, the problem is that, when they get into their liability section, it takes us for the first time to Federal court. There are so many concoctions in there that it is going to be basically very impossible for a patient who has been wronged to have that wrong made right.

Now, there is really a reason why the California Medical Association and the Texas Medical Association and the Medical Association of Georgia have all sent letters to their Members of Congress saying that the Coburn bill would preempt State law. They are right.

My colleagues tried. I congratulate them for trying. But they failed. Let us take a look at what the bill says. Nothing shall be construed to preclude any action under State law not otherwise preempted under this title. The title they are amending is ERISA, section 502.

The courts have consistently ruled from the Pilot Life case on that any remedy that exists under ERISA, section 502, will preempt State law. By allowing a patient to sue in Federal court, their bill creates a new Federal remedy under ERISA, section 502. The courts have consistently ruled a Federal remedy preempts State law. Any cause of action under State law like California or Georgia or Texas that would conflict with a new Federal cause of action they have created is necessarily preempted. Their own language says so. There is no way the Texas, Georgia, and California laws would not be preempted.

Now my colleagues tried. I do not blame them for trying. I would not want to tell the Members from California or Texas or Georgia that my colleagues are preempting their State laws. Then, again, I do not have to do that.

In addition to what we are putting in ERISA, Federal law is supreme and has been so since 1819 and the Barron v. Baltimore case that the Supreme Court ruled on.

Now, that is one of my hiccups being from Georgia, and I think a lot of people might have that, that we are taking away State law.

Let us point out another little problem, because they are in there. Lord knows I am not against the gentleman from Oklahoma (Mr. COBURN). I love his bill except for these little issues, and that is why we have to defeat it.

Under the Norwood-Dingell bill, a person is held accountable for the consequences of the decision based on the medical merits of that decision. If a doctor makes a decision, he is judged on whether or not that decision was good. Good medicine. We want an insurer who overrules a doctor judged by the same standard. We want an insurer who overrules a doctor judged by the same standard. Now, under the Coburn-Shadegg substitute, an insurer will be judged by whether they practice good accounting.

Mr. GOSS. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Tennessee (Mr. BRYANT).

Mr. BRYANT. Mr. Chairman, as we have heard from a number of our doctors today on both sides of this issue, I want to give my colleagues the perspective of an attorney who practiced law representing health care providers in malpractice cases.

I am somewhat confused because I have seen firsthand how unrestricted litigation against doctors and hospitals have caused the cost of medical care to rise dramatically. It caused doctors to practice defensive medicine. It caused premiums to go up and to see the cost of this service, the tests, and all of that to go up to where it is almost unaffordable.

Yet, here, we are today talking about trying to do the same thing to health care organizations. Why do we want to do that?

I have studied these bills, and I have come to a conclusion that there is a need for accountability for managed care. We have to hold them accountable, but we can do so in a fashion that does not chase people out of the health care industry, does not raise the expenses, does not cause more people to become uninsured. That is done in the Shadegg-Coburn bill.

It is a balanced, reasoned, measured approach which holds our HMOs accountable for good care and, on the other hand, does not run people out, does not make it too expensive that we have got more uninsureds on the rolls.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the distinguished gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Chairman, do we need a new Federal tort in this country? Do we want the Federal courts preempting State law in this country? Do we want the Federal courts taking over the traditional role of regulating insurance that is assumed by the States in this country?

I submit to my colleagues that the answer to those questions is no, but that is exactly what Coburn-Shadegg will do, allow Federal courts to preempt State law and create a brand-new Federal tort. Let us create health care in this country for American citizens. Let us do not create new torts.

What happened to local control? What happened to that argument? Do we not trust our own State courts in this country? Do we not respect local government? Do we turn everything over in this country to the Federal courts? Is that what we are about? That is just what this bill does.

I am here to tell my colleagues that, under Coburn-Shadegg, our State courts are gagged just like the doctors are gagged. On the other hand, Norwood-Dingell will not override protections already provided by State laws, States such as Texas, New York, Michigan, Iowa all across this great country. Norwood-Dingell is a common-sense local approach to these problems. If an insurer makes a decision, the insurer is responsible for that decision.

A final matter, the employer is not responsible for the decisions made by others. The employer is not responsible for the decisions made by others. The employer is not responsible for the decision made by others, period. That is what the States say.

Let us create medical care. Let us do not create a new tort.

Mr. GOSS. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from Louisiana (Mr. MCCRERY).

Mr. SHADEGG. Mr. Chairman, will the gentleman yield briefly?

Mr. MCCRERY. I yield to the gentleman from Arizona.

Mr. SHADEGG. Mr. Chairman, I simply want to set the record straight on this issue. Apparently the question of whether or not State law is preempted under Coburn-Shadegg has become important, and I tried to ask the gentleman from Georgia (Mr. NORWOOD) about that issue.

I want to point out that, in his argument, he said that it is preempted because ERISA preempts all State law. That was his premise, because ERISA preempts all State law, and our bill said not otherwise preempted. He said that is the flaw in our logic.

The problem is he is wrong about that. ERISA does preempt all benefits claims, but it does not preempt quality of care claims. That is precisely what the Texas Legislature took advantage of. They wrote a law that says quality of care is not preempted. Georgia, Louisiana, and other States have followed, so his premise is simply wrong.

Mr. McCRERY. Mr. Chairman, I thank the gentleman from Arizona for his comments.

To the gentleman from Texas (Mr. SANDLIN) who spoke so fervently about employers not being liable, I would simply say that, as a lawyer, he knows, and I am a lawyer, and I know that lawyers are not prevented from suing anybody no matter what the wording of any statute is.

I can guarantee him that some lawyers are going to sue employers because they sue everybody, everybody in sight that they think might be brought into court and have a settlement at hand. Those employers are going to have to fight that. Even though they may ultimately win under the wording of the statute, they are going to have to spend a lot of money fighting that lawsuit, and that is part of the problem.

Let us talk about liability for just a minute.

□ 1345

And I understand the American Medical Association is supporting Norwood-Dingell and not supporting Coburn-Shadegg, which is just beyond belief to me. The American Medical Association, as well as some of my colleagues who are supporting Norwood-Dingell, have been fighting for years for medical malpractice reform, saying that the liability system is out of control. And yet, by passing Norwood-Dingell, they would impose on health care plans the same out-of-control liability system they have been complaining about for years on doctors. I just do not get it.

Mr. Chairman, besides the liability issue, though, which I think is clear, Norwood-Dingell does impose on health plans, the same out-of-control liability

system that we have everywhere else, Coburn-Shadegg, on the other hand, puts some reasonable restraints on that liability system. But let us put that aside. Let us talk about the rest of the bill. I think my colleagues, especially on the free market side of the aisle, should be very concerned about the regulatory aspects of Norwood-Dingell. Their bill includes language stating that external appeals panels, for example, can consider as evidence government-issued practice and treatment policies and guidelines.

This gives bureaucrats the potential to outline practice in this country; bureaucrats writing down how health care will be administered, not doctors. Unlike the Coburn-Shadegg substitute, Norwood-Dingell gives unfettered discretion to Federal bureaucrats to determine if health care workers suffered from inappropriate retaliation from their employer.

This bill, the Norwood-Dingell bill, is too heavily regulatory. Vote against it and support the Coburn-Shadegg substitute.

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I would just point out that in our bill we have limited punitive damages. That is a step forward. We go to the State courts because we know that there is a great deal of tort reform around the States, 30 States or so have limited punitives or none, caps on noneconomics.

So I would say that is another good reason not to set up a new Federal tort where we just simply do not have any type of tort reform. And we cannot depend on the States to do the right thing in an area that they have typically and historically controlled for the last 200 years.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the gentleman from Massachusetts (Mr. FRANK).

Mr. FRANK of Massachusetts. Mr. Chairman, for those who have contested the theory of evolution, we have the Republican Party's position on this issue. It has been evolving very rapidly.

We started out with many saying, no, there should not be any basis for lawsuits. They have moved. And I give credit to those who have helped them move, but they have been held back by some who still do not like the notion at all. We now have, apparently, agreement that there should be a right to sue HMOs. That is a considerable evolution. How wholeheartedly some believe in what they agree to, I am not sure. But we do have some agreement.

The question is what kind of lawsuits. And, in fact, what we have are people who have been grudgingly brought to the notion that there should be lawsuits but, because it was grudging, have designed flawed lawsuits. They have designed, surprisingly to me, a Federal supremacy situation which is premised on the notion that we cannot trust the States. Indeed, what we have from some on the other side is a distrust of two entities with whom they have previously professed a lot of solidarity: States and doctors. They have to say that we cannot allow the States the freedom to deal with the lawsuits, and they also show a distrust of doctors.

I also want to talk about the kind of lawsuits. Members on the other side have said, well, how has the AMA switched their position. These are very different kinds of malpractice lawsuits. Whatever we think of the other kinds of malpractice lawsuits, they are cases where the doctor who treated the patient is being sued and other people who did not treat that patient are coming in.

Here the lawsuits authorized are a very specific kind. They will require the cooperation of the doctor who treated that patient. Here the malpractice claim is that the doctor who actually treated the patient was overruled and interfered with. So the doctor who treated the patient stands as a gatekeeper to prevent illegitimate lawsuits.

Mr. GOSS. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from California (Mr. THOMAS).

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

Mr. THOMAS. Mr. Chairman, while we are talking about evolution, let us talk about the fact that there are a number of unions that support the Norwood-Dingell bill. And why in the world would the American Medical Association align itself with unions? Perhaps my colleagues were asleep when the American Medical Association decided to adopt collective bargaining.

The arguments that we have heard, no matter how strongly or forcefully presented about the fact that the coalition bill tramples State law, are simply wrong. Let us not try to rely on each other. Let us go to the independent, professional attorneys that we have relied on since Congress created itself, the Congressional Research Service. Those lawyers, totally objective, analyzing the coalition bill said this: ''This provision would not interfere with, but would support, a recent holding in a Federal district court decision upholding the ordinary care provision of the Texas law.''

Now, my friend is a lot of things, but the gentleman from Georgia (Mr. NORWOOD) is not an attorney. The Congressional Research Service says the coalition bill supports State law.

Now, if we want to meet a trial lawyer, follow an ambulance. If we want to know who is supporting this measure, take a look at their list of supporters. On the coalition bill we will find that virtually medical association for medical association they match. But we cannot stay with them when the unions endorse their provision and the trial lawyers support their provision.

Why? Because people whose lives are on the line, in terms of their economic survival, say this: ''The Chamber of Commerce strongly opposes any proposal which permits jury trial lawsuits for unlimited punitive and compensatory damages.''

Do we believe the trial lawyers? No. Who will butter their bread? Take a look at the list of supporters of the coalition. We do not have the trial lawyers. Take a look at Norwood-Dingell. The trial lawyers and the doctors are together. Now, talk about evolution. Not only are they going to be following an ambulance, but they are going to be in the ambulance.

This is exactly the wrong approach to take when employers still have the ability to say, yes, I will provide health insurance; or, no, I am not going to run the risk of unlimited punitive and compensatory damages. That is the risk that will be run if Norwood-Dingell becomes law. And I can assure my colleagues that employers will say, at some point, it is not worth the risk. Do not feed trial lawyers.

Mr. DINGELL. Mr. Chairman, I yield 15 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I just want to point out to the gentleman from California (Mr. THOMAS) that we all try to use independent, well-experienced lawyers. The lawyer from CRS who says that we do not preempt State law is out of law school for 3 years and has never practiced ERISA law. We tried to find some experienced people to do our ruling.

Mr. DINGELL. Mr. Chairman, I yield 2½ minutes to the gentleman from Missouri (Mr. GEPHARDT), the minority leader.

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

Mr. GEPHARDT. Mr. Chairman, I rise in opposition to the Coburn-Shadegg amendment and to speak for the Norwood-Dingell bill. And I want to commend the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and all of the Republicans and Democrats who have worked so hard on this bill and especially the gentleman from Michigan (Mr. DINGELL) for all that he has done to make this happen.

The Coburn-Shadegg amendment, in my view, does not do what it claims to do. It fails to hold health care providers accountable. It lets them off the hook. It will not go far enough to guarantee that American families get the health care they need. In my view, only the Norwood-Dingell bill will return control of medical care back to where it belongs, to doctors and patients. It will deliver much-needed patient protections at a small cost to consumers and to business. I believe the cost is a modest price to pay to restore the much-needed balance in our health care system.

The health insurance lobby and their allies are spreading a false message that the Norwood-Dingell will and managed care reform will force employers to drop plans and will cause a

loss of jobs and blunt economic growth. This is not reality. All we have to do is look at the experience in Texas, which has had a bill much like the Norwood-Dingell bill. Information filed with the Texas State Department of Insurance shows that there has been no unusual increases in costs in HMOs. In fact, national HMOs that operate in Texas and other States have higher cost increases outside Texas.

A recent study by the Kaiser Family Foundation found that the premium increases likely to result from a bill like Norwood-Dingell would be very modest. In fact, their study showed that it would result in a premium increase of less than 1 percent to a typical HMO policyholder.

Now, let me say to the Members that if somebody is sick in my own family and is not getting the care that the doctor believes they should get, I can assure my colleagues that paying less than 1 percent more for a policy that would give me enforceable rights would be something that I would leap at, and I think all my colleagues would leap at, if someone in their family was direly sick.

I have said many times that back in the early 1970s my son was diagnosed with terminal cancer, given no hope. The pediatrician said, he is going to be dead in 6 weeks. Then another doctor came in the room and said, we got on the computer last night and we think we found something that might work. This was back in 1972. I had good insurance, thank God. He got the therapy. If that doctor had come in the room and said, we typed in the computer and we found a triple drug therapy but the HMO has refused it, boy, I would have wanted to pay that extra 1 percent or half a percent to get the right to have that happen.

And let me say, with all respect to my friends who have brought these other alternatives, the reason that we want enforceability and accountability and a right to get to court after a review by physicians is we want pressure on these HMOs and health insurance companies to make the decisions in accordance with what doctors and patients need.

This is an important moment. This is the right bill. I urge Members to turn down these alternatives. I have great respect for the people who have written them and their motive and intent; but with all my heart I say to the Members of the House of Representatives today, this Norwood-Dingell bill is the right bill for the people of this country. If somebody is sick in your family, you are going to need this bill. Turn down these alternatives and vote for this very, very positive piece of legislation.

□ 1400

Mr. GOSS. Mr. Chairman, I yield 5 minutes to the distinguished gentleman from Oklahoma (Mr. COBURN) who is the principal author of the patient protection act of this substitute.

Mr. COBURN. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, this is an issue that is very important to many of us. I have spent 21 years of my life in the medical field. Myself and one other doctor in this body goes home and practices every weekend. We all agree that there needs to be certain basic things changed. Everybody that voted on the last bill all know that all those basic things need to be changed.

Why? Because there were four Members in this body that really wrote them: The gentleman from Iowa (Mr. GANSKE), the gentleman from Oklahoma (Mr. COBURN), the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Arizona (Mr. SHADEGG). They constitute the entire base bill of all the bills that are written. We all agree on that. What we do not agree on, however, is what the risks are of going too far.

I believe that all in this debate are well-intended. And other than the statements made by our friend from Massachusetts, I believe all the motives are good. He said our motives are not good, we have been pulled. We have not been pulled. We care about patients immensely. The question is do we care just in the short-run? Are we only going to solve the problem now and then have to come back and fix a bigger problem?

I am known for my independence in this body. I have taken the AMA foursquare for their position, which puts people's future health care benefit at risk. And why are they doing it? They have a persecution complex. They have been sued out the kazoo. And if it is good enough for them, it is good enough for everybody else.

I am a pro-business conservative. I have had the ''little you know what'' beat out of me from the people who are my friends. Why would I position myself in the middle of those two? Because I want to fix health care. Not just now. I want to fix it down the road. And I do not want what we are about to do to end up being the reason why the Government is going to have to run health care.

Mr. Chairman, I want to tell my colleagues, if they do not believe that is true, listen to this: The closest the Health Care Financing Administration has ever come on any estimate of any cost with Medicare/Medicaid, they missed it by 800 percent. So just take .3 or 1 percent, multiply it by 800 percent, and that is what we are going to see.

There are motivations other than caring for the patients in this debate, and they are big business not wanting to pay the cost of full care. There are HMOs who oftentimes, too often, the bottom line is the most important thing. And there is the trial bar who will extort, we cannot deny it, they will extort businesses. And they will raise costs. And under the claim of a good purpose but all too often as a lawsuit that is intended to only do one thing, extort money because it costs more to defend than it does to settle.

I do not deny that there are serious problems in our health care delivery system. I have worked hard with my friend, the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Iowa (Mr. GANSKE) to try to solve those. But I beg this body to consider what we do. If we go too far and if we do not go far enough, we have failed. And if we fail, everyone in this country loses.

Government-run health care will kill the quality and leading nature of this country's health care. That is really what we are talking about. We are not really talking about lawsuits. We really are not talking about employer-based helped care. What we are talking about is getting over the brink to where what is going to happen is we are going to fulfill our obligation with a Government-run program.

And then talk about costs, talk about the ability to control care, talk about meeting our obligations to Social Security. We cannot even meet our obligations in Medicare now. How are we ever going to do that?

So as my colleagues consider this vote, think about why I would place myself against both sides of my friends, both sides. Because it is right and because it is correct. It does not do everything that the Norwood-Dingell bill does. We know that. But let us go here first. Let us hold plans accountable. There is no denying that we hold them accountable. The gentleman from Georgia (Mr. NORWOOD) knows that. It is how we hold them accountable and what are the costs associated with that.

I would beg my colleagues to look and walk before we leap. Our patients are worth that much.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to my good friend the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, this is the painful part. It is not any fun going against our friends. And the gentleman from Oklahoma (Mr. COBURN) is my friend. Of course, I wish he would not go against our bill which he worked so hard on and so long to help us write.

My colleagues, what this really is all about is about two very strong American principles. It is about the right to choose in this country and choose our own doctor, and it is about the right to ask people to be responsible for their actions. We do that all the time, and it is time that we ask the insurance industry to be responsible for its actions.

I am going to vote against the Coburn amendment because all the good things he has in his bill that he knows I agree with, he is right, I did help him write them, but I am going to vote against him because they really have gone too far with their liability part. And yes, they do and will make insurance companies liable in Federal court. There is no question that they will. But the problem is the poor patient has to jump through so many hurdles before they can get there.

It is correct for us to not endorse frivolous lawsuits and extortion that

happens out there in the legal profession today. We know that. That is why we have tried to do our best to protect the employers.

But I cannot support his bill because I have to worry about and I am worried about and I have been for 5 years, tomorrow, today, it is about that mother today who took her child to the pediatrician and the doctor says her child needs to be hospitalized and the insurance industry 2,000 miles away says, no, we cannot do that.

It is about a friend of mine, Bob Schumacher, who, like me, is a small businessman and lives in Macon, Georgia. Bob used to be a member in NFIBE. He used to be a member in the Chamber of Commerce. But his wife is dying and the plan that he bought as the employer will not pay the benefits, and he basically has no recourse today. I want him to get recourse and get it fast, and we think in our bill that is the best way to do that.

Mr. GOSS. Mr. Chairman, I yield the balance of my time to the distinguished gentleman from Illinois (Mr. HASTERT), the Speaker of the House.

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

Mr. HASTERT. Mr. Chairman, I rise today in strong support of the coalition substitute.

As many of my colleagues know, I have been involved in this whole idea of health care and health care reform for a long time, probably longer than I want to remember.

One of the things we have strived for is to be able to get people into health care, into the situation where they need to get treatment, try to get people into hospitals' rooms and doctors' offices and not necessarily going into lawyers' offices and courtrooms before they can get that treatment.

I have always believed that we have three goals in health care. It must be affordable. It must be available. And it must be accountable. If it is not affordable, it is not available. Trying to change a system and keep a balance so that we do not change that system too much that we completely upset it so patients cannot get the care that they need is the task before this House, to try to find balance to try to do those things that are the right things.

As we debate these bills and these options before us today, there are a lot of similarities. People getting the access, people being able to get into emergency care, getting to their caregiver, their pediatrician, or their Ob-Gyn so that they can take care of them. They are all the same. I have written that legislation for years. The gentleman from Georgia (Mr. NORWOOD) helped me to do it. And this is all the same.

The difference in these bills is to some a fine line, but the difference in these bills is how far we go, how far that we give license to the trial lawyers, how far that we take the incentive away from corporate and employers to provide health care for their employees.

I am pleased that the House passed an access bill yesterday in a bipartisan fashion that will help address the problem of the 44 million uninsured today. It would be shameful to take up the important issue of patient protections without doing something to protect the uninsured.

As my good friend the gentleman from Florida (Mr. GOSS) put together a package that does both, he wrestled with many issues, how to make sure that managed care plans come through on their promises to their patients, how can we be certain that patients get the care they need when they need it.

Mr. Chairman, the coalition substitute developed by the gentleman from Florida (Mr. GOSS), the gentleman from Oklahoma (Mr. COBURN), the gentleman from Arizona (Mr. SHADEGG), the gentleman from Pennsylvania (Mr. GREENWOOD), and the gentleman from California (Mr. THOMAS) is an excellent product. It took us a while to reach this point. Consensus takes time. But we have got a solid, balanced approach that I urge my colleagues to support.

This is what the coalition bill does: It provides access to binding, independent decisions by doctors. For patients, we enforce their rights in court. And if they are harmed, they have access and rights to go back to court and get their damages. We protect employers who offer health care as a voluntary benefit. And we do not end fee-for-service medicine. We protect States like California and Texas that have already passed the right to sue legislation.

Sound reasonable? I think so. What could possibly be the reason for division on such a common-sense approach? It is very simple. We do not protect the trial lawyers. We do not force people to sue their way to get better health care. We do not provide windfalls for the trial lawyers. We want to show them something. We want to show them a common-sense way.

I want to also show my colleagues something else. This is a class list from the University of Texas Law School. It is a class list of all kinds of courses on how to sue an HMO. Probably that is relevant in Texas. Folks in Texas argue that the right to sue has not increased costs and they have not exploded. And they may be right so far.

But under the Norwood-Dingell legislation, trial lawyers will be given unprecedented new rights to sue any time for any reason in any venue. The truth is no one has any idea what the cost implications can be when they go too far. The coalition bill, instead, gives patients the care they need when they need it.

My colleagues, we have come to an important point in this Congress in this debate. If we want to protect patients, vote for Goss. I urge support for the coalition substitute. And when it passes, I want to urge my colleagues to vote yes on final passage to move this legislation forward.

□ 1415

Mr. DINGELL. Mr. Chairman, I yield the balance of my time to the distinguished gentleman from Arkansas (Mr. BERRY).

The CHAIRMAN. The gentleman from Arkansas is recognized for 2¼ minutes.

Mr. BERRY. Mr. Chairman, I rise in opposition to this amendment and in support of the bipartisan Norwood-Dingell bill. Let me tell my colleagues one of the reasons why.

Under the Coburn-Shadegg amendment non-economic damages are limited to the lesser of two times economic damages or $500,000. As was already mentioned, the Cocoran case that the gentleman from Arizona (Mr. SHADEGG) talked about, since the victim was a baby with no earnings, economic damages are minor, possibly only the cost of a funeral. Do my colleagues want to tell the Cocorans that the life of their baby is only worth a couple of thousand dollars? Under the Coburn-Shadegg amendment that is all that they would receive. That is one of the reasons I am opposed to this amendment.

Unlike this substitute which creates a new Federal bureaucratic process, the Norwood-Dingell legislation would allow States to determine whether such liability should be expanded to self-insured plans.

Let me say this again. The Norwood-Dingell bill allows States to determine whether HMOs should be held liable, and it allows States to determine which limits to set on damages.

The gentleman from Oklahoma (Mr. COBURN) says that letting the States decide goes too far. I disagree. The State of Texas, which the Speaker just referred to, has only had three lawsuits in its experience with a very similar bill as we are about to pass. Only in States that allow such suits and only in cases where a person has gone through a competitive internal and external review process could a lawsuit be filed, and if a health insurer or HMO abided by the review process, it could not be sued for punitive damages.

Most important, the Norwood-Dingell bill specifically prohibits lawsuits against employers, unless an employer makes a medical decision to deny a covered benefit and a patient is seriously harmed as a result. Norwood-Dingell specifically prohibits the suit to an employer.

These safeguards virtually ensure costly trials. Unreasonable verdicts will not result. At the same time it will ensure insurance companies and HMOs provide the benefits that employers and employees have paid for.

Mr. HUTCHINSON. Mr. Chairman, presently, this Nation is awash with a sea of discontent—a belief, in our Nation, that managed care has eroded the traditional reliance of patients on the decisions and recommendations of the physicians.

Because of the growing discontent of patients who are subject to managed care agreements, Congress is prepared to step in with

additional patient protections and rights and to make sure those rights are enforceable. As we consider changes to our managed care system we need to keep in mind our guiding principles:

First, patients should be able to choose their own doctor—the most basic decision on health care. This means that a managed care agreement must allow a point of service option allowing patients to pay for procedures and physicians not covered by their plans; patients must also be guaranteed access to customary specialities such as OB/GYNs and pediatricians.

Second, physicians should be free to discuss all medical options with their patients—this means a prohibition of gag rules which restrict physicians from recommending all medical options with the patient;

Third, members of managed care plans should have immediate access to an emergency room based on a prudent lay person's standard and not be second guessed by an office clerk reviewing an emergency room bill thirty days after an emergency.

Finally, the protections and rights for patients are useless without the means for accountability and liability if those rights are ignored.

When organizations like insurance companies determine issues of medical necessity, they need to stand behind those decisions. However, while I believe there must be accountability, there also must be safeguards for employers who provide healthcare as a benefit and do not make medical decisions. Healthcare insurance is an employer sponsored system, and we must be careful that we maintain that system and encourage it to grow. Already, we have too many people who are without insurance, and we do not want to see those numbers rise because Congress irresponsibly passed legislation that drove up the cost of healthcare in a dramatic fashion.

Mr. Chairman, the bill before us that protects the patient and follows these guiding principles is the Goss, Shadegg, Coburn, Greenwood and Thomas Substitute. This requires group health plans to have a grievance system as well as an internal and external appeals process.

This would also allow a patient recourse when there is a denial of coverage if the benefits would exceed a hundred dollars. The legislation requires decisions within 14 days or 48 hours in expedited cases. In addition, for the first time a patient would be able to take the responsible party into court to protect their rights. The purpose of the court access is to protect rights, recoup damages and not to punish the healthcare plan if the plan is following the recommendation of the appeals review.

Just as important, employers who provide a self-funded health insurance plan will not be held liable unless they directly participate in the medical decisions of the plan. This provides adequate balance between patient protection and avoids astronomical price increases on health insurance premiums.

Mr. Chairman, I ask my colleagues to support the balanced approach of the patient protection provisions in Dr. COBURN's substitute amendment.

Mr. HILL of Montana, Mr. Chairman, Americans enjoy the best quality health care in the world. However, our system for delivering care can still be frustrating for patients, providers and employers. True comprehensive health care reform in my opinion must include the three A's—Accessibility, Affordability and Accountability. Yesterday, the House passed H.R. 2990 which will improve the accessibility and affordability in health care that we need today.

Today, we need to complete the Trifecta and address the most difficult of the three A's—Accountability. During the debate today we will have an opportunity to vote on four different ways to address the accountability issue. The main issue that we are debating when discussing patient protection legislation is how do we bring about accountability for insurance companies without creating a whirlwind of frivolous litigation.

Americans want and deserve patient protections, they do not want more lawsuits. And they don't want to fight with their employer, their doctor, or their insurance provider.

That is why I support the Coburn-Shadegg substitute to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act.

There are a number of reasons that I feel this solution is the best for both patients and providers. I believe this substitute ensures responsibility by holding insurance companies accountable to patients by allowing physicians to make medical decisions. First, Coburn/Shadegg allows employers to provide health insurance to their employees without exposing them to increased litigation. Under this substitute, employers can not be held liable for providing health care coverage, selecting a plan, selecting a third-party to administer, determining coverage or increasing or reducing coverage, or intervening on behalf of an employee. Under H.R. 2723, the employer will be subject to lawsuits which in turn, I fear, will cause employers to drop their health plans for their employees.

Second, Coburn/Shadegg instills reasonable accountability. The substitute requires an exhaustion of administrative remedies required. Patients are allowed to go through an internal and external appeals process before going to court. This gives patients an expedited forum to air grievances. Most importantly, the appeals are decided by an independent panel of doctors, not by bureaucrats or insurance claims adjusters, not by lawyers or judges.

Under this substitute there is no liability for consequential damages if the plan's doctor's decision is upheld by the independent external appeals entity. The goal is to encourage care and the good decision making at the earliest point in time. We need to avoid a process such as that created in the Norwood/Dingell bill that would produce an avalanche of frivolous lawsuits. We can address the very real concern of patients in managed care plans by empowering patients, not trial lawyers, and do so by passing Coburn/Shadegg.

I want patients to get the care they are entitled to when they need it, not allow their heirs to sue for some large settlement after they die. In the end, excessive lawsuits will only take money away from care and put it into the pockets of attorneys. That is an unacceptable result.

By adopting the Coburn-Shadegg substitute, we will be completing the three A's—Accessibility, Affordability and Accountability. Only when we have the three A's, is when we have a common-sense approach to comprehensive health care reform that will make health insurance companies more accountable and give patients more choices.

Mrs. FOWLER. Mr. Chairman, today I rise in support of the Goss-Coburn-Shadegg substitute. I, too, have heard of the excesses of some managed care plans from constituents and doctors in my district. I agree that these excesses must be curtailed and that the health care plans should be held accountable when they practice bad medicine.

However, I do not believe that the only way to hold them accountable is to open them up to lawsuits without limits.

The Norwood-Dingell bill does not distinguish between managed care insurance and traditional fee-for-service insurance. Fee-for-service plans merely reimburse for care; they do not engage in the type of medical decision-making that we seek to address through this debate. This substitute, on the other hand, makes the distinction and protects fee-for-service plans from expanded liability.

This substitute, like the Norwood-Dingell bill, establishes internal and external review processes through which doctors make determinations about what care is appropriate for their patients. But, unlike the Norwood-Dingell bill, this substitute allows those processes a chance to work before sending patients to court.

Mr. Chairman, the ultimate goal we all share is to ensure that patients get the care that they need when they need it. An expedited review process like that set up in this substitute will get patients that care much more quickly than a lengthy lawsuit.

But should the insurance company defy the determinations of those independent doctors, and as a result a patient is injured or dies, court may be the only option. This substitute allows for full recovery of economic damages, but caps the non-economic and punitive damages that can be won so that they are fair.

Furthermore, Mr. Chairman, this substitute strikes the appropriate balance between the rights to patients to seek redress of their grievances and the legitimate concerns of employers of being subjected to unlimited lawsuits. Unlike the Norwood-Dingell bill, Mr. Chairman, this substitute, through very specific language, will protect employers who do the right thing and provide health insurance coverage to their employees.

Without this employer protection, more employers will be forced to drop their insurance coverage for their employees. Without these limits on liability, premiums will rise and more people will be unable to afford insurance coverage. If these things happen, Mr. Chairman, then all we've done here today and yesterday will have been for naught.

Mr. CLAY. Mr. Chairman. I rise in opposition to the Coburn substitute. This substitute is nothing more than a fig leaf to permit Members to say they voted for something on liability without giving the American people any real rights. Under this substitute it is so difficult to get to court that almost no one will be able to be redressed in court.

First, under Coburn, individuals may only go to court after they have exhausted all internal and external plan appeals. No exception. Even if injury has already occurred. Or if appealing would be futile. This is tougher than current ERISA law which permits individuals to go to court if the court finds the internal process futile.

Second, individuals may only bring suit in federal court. The backlog is far greater in federal court than in state court. Individuals who

do not live in big cities will have to travel long distances if they have been harmed.

Third, Coburn only permits individuals to sue the ''final decision maker''. This alone can be an impossible standard for an individual. Most individuals do not know who denied their claim and they certainly don't know who the final person was.

Furthermore, Coburn includes an unprecedented and likely unconstitutional limitation on the court's power to hear the case. Under Coburn, health plans can contract with private entities and permit them to determine if an individual was harmed and whether it was due to the plan's failure. If the private contractor finds for the health plan, then the court must dismiss the lawsuit unless there is clear and convincing evidence to the contrary. This is an unprecedented intrusion on the power of the courts. A private entity cannot determine whether there is a case or not. That is for the courts and the courts alone.

Even worse, Coburn mandates that the court award losing attorneys' fees and court costs if an individual's case is dismissed. Few working people can afford to go to court if they may be forced to pay the health plan's attorneys' fees if they lose.

Coburn is not a serious liability amendment. It makes it so difficult for an individual to bring a suit that almost no one will be able to go to court. Don't be fooled by this Trojan Horse. The American people want real rights and real reform. Support the Norwood-Dingell compromise.

Mr. KOLBE. Mr. Chairman, for the last 10 months, I've researched, analyzed, listened, and questioned, searching for the right answer to this policy conundrum. I believe there are four guiding principles that should govern any response:

(1) Legislation should permit an individual to sue an HMO as long as the amount of damages are reasonably related to the economic loss.

(2) Legislation should permit the right to sue over covered benefits only.

(3) Legislation should emphasize mediation over litigation.

(4) Legislation must provide sufficient protections for the employer—not the HMO—from lawsuits, unless the employer is actively engaged in making the health care decisions of the HMO.

In my view, Norwood-Dingell runs counter to these principles. Specifically, the bill would:

Allow lawsuits by anyone. No actual injury is required to recover damages under H.R. 2723.

Allow lawsuits at any time. H.R. 2723 does not require patients to seek administrative remedies—including internal and external appeals—before proceeding to litigation.

Allow lawsuits over anything. Plaintiffs may challenge any coverage decision or action by an HMO they disagree with, even if the procedure or service is not a covered benefit.

Allows lawsuits even when the HMO does everything right. Under H.R. 2723, an HMO may be sued even when it made the right decision according to an external medical review conducted by independent physicians.

Allows lawsuits without limits. This bill would let a patient sue for unlimited damages, driving up health care costs.

The Coburn-Shadegg substitute, however, meets these criteria. The bill:

Provides reasonable, but limited, liability for HMOs.

Protects employers from harassing litigation unless they choose to directly participate in any final decision to deny care.

Requires plaintiffs to complete an internal and external review process before proceeding to court.

Restricts lawsuits to covered benefits only, eliminating judicially mandated benefits.

To my colleagues here today, I say this: the Coburn-Shadegg substitute borrows the best of the Norwood-Dingell bill, rejects its worst, and improves upon the rest. It is a final example of pragmatic policy and deserves your support. It is essential that common sense and the common good prevail over rhetoric and political gamesmanship. I urge my colleagues to support the Coburn-Shadegg substitute. Americans are in need of a solution to this problem, not an issue for next year's elections.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from Florida (Mr. GOSS).

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. GOSS. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 193, noes 238, not voting 3, as follows:

[Roll No. 488]

AYES—193

Aderholt
Archer
Armey
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Biggert
Bilirakis
Bliley
Blunt
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth-Hage
Coble
Coburn
Collins
Combest
Cooksey
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Fossella
Fowler
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
LaTourette
Lazio
Lewis (CA)
Lewis (KY)
Linder
Lucas (KY)
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Myrick
Nethercutt
Ney
Northup
Nussle
Ose
Oxley
Packard
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Salmon
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOES—238

Abercrombie
Ackerman
Allen
Andrews
Bachus
Baird
Baldacci
Baldwin
Barcia
Barr
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bilbray
Bishop
Blagojevich
Blumenauer
Boehlert
Boehner
Bonilla
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Cook
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Foley
Forbes
Ford
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Ganske
Gejdenson
Gephardt
Gilman
Gonzalez
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Horn
Hostettler
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Leach
Lee
Levin
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntosh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Quinn
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Saxton
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Terry
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOT VOTING—3

Cox
Kaptur
Scarborough

□ 1439

Mr. WALSH changed his vote from ''no'' to ''aye.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

AMENDMENT NO. 3 IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. HOUGHTON

Mr. HOUGHTON. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 3 in the nature of a substitute offered by Mr. HOUGHTON:

Strike out all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievances and Appeals

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

Subtitle B—Access to Care

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

Subtitle C—Access to Information

Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

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

Subtitle E—Definitions

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

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

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

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

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 302. Additional judicial remedies.
Sec. 303. Availability of binding arbitration.

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

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

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

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

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

Sec. 601. Health care paperwork simplification.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—

(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B).

(B) DEADLINE.—

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

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

(I) receives a request for a prior authorization,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in

no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for prior authorization.

(2) ONGOING CARE.—

(A) CONCURRENT REVIEW.—

(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

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

(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 113, respectively.

(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the reasons for the denial (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 102; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

(1) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

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

SEC. 102. INTERNAL APPEALS PROCEDURES.

(a) RIGHT OF REVIEW.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

(A) shall provide adequate notice in writing to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied (within the meaning of section 101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in a manner calculated to be understood by the participant, beneficiary, or enrollee; and

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

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

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

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

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

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

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

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

(2) TIME LIMITS FOR INTERNAL REVIEWS.—

(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

(B) DEADLINE.—

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

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

(I) receives a request for internal review,

(II) determines that additional information is necessary to complete the review and make the determination on the request, and

(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 72 hours after the time of the request for review.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

(A) in which, as determined by the plan or issuer or as certified in writing by a treating health care professional, the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function; or

(B) described in section 101(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

(2) PROCESS.—Under such procedures—

(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 72 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant, beneficiary, or enrollee involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, enrollee, designee, or provider, proceed directly to seek

further appeal through any applicable external appeals process.

SEC. 103. EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which an appeal is made, within 180 days after completion of the plan's internal appeals process under section 102, either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term ''externally appealable decision'' means a denial of claim for benefits (as defined in section 101(f)(2))—

(i) that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or

(ii) in which the decision as to whether a benefit is covered involves a medical judgment.

(B) INCLUSION.—Such term also includes a failure to meet an applicable deadline for internal review under section 102.

(C) EXCLUSIONS.—Such term does not include—

(i) specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment; or

(ii) a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 102(d), a plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 102, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(4) FILING FEE REQUIREMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan or issuer may condition the use of an external appeal process upon payment to the plan or issuer of a filing fee that does not exceed $25.

(B) EXCEPTION FOR INDIGENCY.—The plan or issuer may not require payment of the filing fee in the case of an individual participant, beneficiary, or enrollee who certifies (in a form and manner specified in guidelines established by the Secretary of Health and Human Services) that the individual is indigent (as defined in such guidelines).

(C) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse or modify the denial of a claim for benefits which is the subject of the appeal.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Except as provided in subparagraph (D), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The applicable authority shall implement procedures—

(i) to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner, and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that all costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be construed as applying to the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT QUALIFIED EXTERNAL APPEAL ENTITY FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

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

(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's or issuer's decision is in accordance with the medical needs of the patient involved (as determined by the entity) taking into account, as of the time of the entity's determination, the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraph (D). If the entity determines the decision is in accordance with such needs, the entity shall affirm the decision and to the extent that the entity determines the decision is not in accordance with such needs, the entity shall reverse or modify the decision.

(C) CONSIDERATION OF PLAN OR COVERAGE DEFINITIONS.—In making such determination, the external appeal entity shall consider (but not be bound by) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms.

(D) EVIDENCE.—

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

(I) the decision made by the plan or issuer upon internal review under section 102 and any guidelines or standards used by the plan or issuer in reaching such decision;

(II) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed; and

(III) the opinion of the individual's treating physician or health care professional.

(ii) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

(I) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(II) The results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies.

(III) Practice and treatment guidelines prepared or financed in whole or in part by government agencies.

(IV) Government-issued coverage and treatment policies.

(V) Community standard of care and generally accepted principles of professional medical practice.

(VI) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

(VII) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine—

(i) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

(ii) whether an externally appealable decision involves an expedited appeal; and

(iii) for purposes of initiating an external review, whether the internal review process has been completed.

(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to the external appeal entity to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity.

(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

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

(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 72 hours after the time) of requesting an external appeal of the decision;

(iii) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek further review by the courts (or other process) of the external appeal determination.

(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity reverses or modifies the denial of a claim for benefits, the plan or issuer shall—

(i) upon the receipt of the determination, authorize benefits in accordance with such determination;

(ii) take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

(iii) submit information to the entity documenting compliance with the entity's determination and this subparagraph.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

(A) The entity meets the independence requirements of paragraph (3).

(B) The entity conducts external appeal activities through a panel of not fewer than 3 clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1)—

(I) by the Secretary of Labor;

(II) under a process recognized or approved by the Secretary of Labor; or

(III) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph); or

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

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

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

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

(i) the number of cases reviewed;

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

(iii) the length of time in making determinations on those cases;

(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

(v) such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted.

(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—

(i) FOR EXTERNAL REVIEWS UNDER GROUP HEALTH PLANS.—For purposes of subparagraph (A)(i)(III), the Secretary of Labor may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(i)(I).

(ii) FOR EXTERNAL REVIEWS OF HEALTH INSURANCE ISSUERS.—For purposes of subparagraph (A)(ii)(II), the Secretary of Health and Human Services may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external review entities. Such an organization shall only be certified if the organization does not certify an external review entity unless it meets standards required for certification of such an entity by such Secretary under subparagraph (A)(ii)(II).

(3) INDEPENDENCE REQUIREMENTS.—

(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

(i) the peer or entity does not have a familial, financial, or professional relationship with any related party;

(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(iii) except as provided in paragraph (4), the plan and the issuer have no recourse against the peer or entity in connection with the external review; and

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

(B) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

(ii) the health care professional that provided the health care involved in the coverage decision;

(iii) the institution at which the health care involved in the coverage decision is provided;

(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision; or

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

(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—The determination by an external appeal entity under this section is binding on the plan and issuer involved in the determination.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(1) MONETARY PENALTIES.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(A) to cease and desist from the alleged action or failure to act; and

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

(3) ADDITIONAL CIVIL PENALTIES.—

(A) IN GENERAL.—In addition to any penalty imposed under paragraph (1) or (2), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(i) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity in violation of the terms of such a plan, coverage, or this title; or

(ii) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or plans or coverage.

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

(i) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice, or

(ii) $500,000.

(4) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in paragraph (3)(A) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce actions.

SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

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

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

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

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

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

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

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

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such nonnetwork coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

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

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

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

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

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

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)), and

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

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

SEC. 114. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection (a)(3)(A)) with respect to the ongoing special condition.

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of gynecological care (including preventive women's health examinations) and pregnancy-related services provided by a participating health care professional, including a physician, who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(2) shall treat the ordering of other obstetrical or gynecological care by such a participating professional as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider.

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

SEC. 117. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) DEFINITIONS.—For purposes of this section:

(A) ONGOING SPECIAL CONDITION.—The term ''ongoing special condition'' has the meaning given such term in section 114(b)(3), and also includes pregnancy.

(B) TERMINATION.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this subsection with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

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

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

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

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

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

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

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

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

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

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

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

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

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

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

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

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

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

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

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

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

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

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

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

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

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

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

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

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

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

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

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

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

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

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

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

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

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

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

(B) Out-of-network coverage (if any) provided by the plan or coverage.

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

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

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

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 112(b)(2).

(H) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals.

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

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

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

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

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(8) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

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

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) NOTICE OF REQUIREMENTS.—Notice of the requirements of this title.

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 101, including under any drug formulary program under section 118.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—A general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which a specified prospective or treating health care professional is (or would be) compensated in connection with the provision of health care under the plan or coverage.

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

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

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

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

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

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

(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

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

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

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

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

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

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

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

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

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

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

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

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

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

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

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

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

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

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

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

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

(2) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

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

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

(3) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, an actively practicing physician (allopathic or osteopathic) or other actively practicing health care professional who holds a nonrestricted license, and who is appropriately credentialed in the same or similar specialty or subspecialty (as appropriate) as typically handles the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician (allopathic or osteopathic) may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

(4) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974 and in section 2791(a)(1) of the Public Health Service Act.

(6) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(8) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

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

(10) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(11) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

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

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

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

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

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

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

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

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

(A) reimburses hospitals, health professionals, and other providers on the basis of a rate determined by the plan or issuer on a fee-for-service basis without placing the provider at financial risk;

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

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing coverage for any services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

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

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

"SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

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

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

"SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 112 (relating to choice of providers).

''(B) Section 113 (relating to access to emergency care).

''(C) Section 114 (relating to access to specialty care).

''(D) Section 115 (relating to access to obstetrical and gynecological care).

''(E) Section 116 (relating to access to pediatric care).

''(F) Section 117(a)(1) (relating to continuity in case of termination of provider contract) and section 117(a)(2) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(G) Section 118 (relating to access to needed prescription drugs).

''(H) Section 119 (relating to coverage for individuals participating in approved clinical trials.)

''(I) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the internal appeals process and the grievance system required to be established under sections 102 and 104, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 103, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

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

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 302. ADDITIONAL JUDICIAL REMEDIES.

(a) CAUSE OF ACTION RELATING TO DENIAL OF HEALTH BENEFITS.—Section 502(a) of the

Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended—

(1) by striking ''or'' at the end of paragraph (8);

(2) by striking ''amounts.'' at the end of paragraph (9) and inserting ''amounts; or''; and

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

''(10) by a participant or beneficiary of a group health plan (or the estate of such a participant or beneficiary), for relief described in subsection (n), against a person who—

''(A) is a fiduciary of such plan, a health insurance issuer offering health insurance coverage in connection with such plan, or an agent of such plan or the plan sponsor,

''(B) under such plan, has authority to make the sole final decision described in subsection (n)(2) regarding claims for benefits, and

''(C) has exercised such authority in making such final decision denying such a claim by such participant or beneficiary in violation of the terms of the plan or this title and, in making such final decision, failed to exercise ordinary care in making an incorrect determination in the case of such participant or beneficiary that an item or service is excluded from coverage under the terms of the plan,

if the denial is the proximate cause of personal injury to, or the wrongful death of, such participant or beneficiary.''.

(b) JUDICIAL REMEDIES FOR DENIAL OF HEALTH BENEFITS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsections:

''(n) ADDITIONAL REMEDIES FOR DENIAL OF HEALTH BENEFITS.—

''(1) IN GENERAL.—In an action commenced under paragraph (10) of subsection (a) by a participant or beneficiary of a group health plan (or by the estate of such a participant or beneficiary) against a person described in subparagraphs (A), (B), and (C) of such paragraph, the court may award, in addition to other appropriate equitable relief under this section, monetary compensatory relief which may include both economic and noneconomic damages (but which shall exclude punitive damages). The amount of any such noneconomic damages awarded as monetary compensatory relief—

''(A) in a case in which 2 times the amount of the economic damages awarded as monetary compensatory relief is less than or equal to $250,000, may not exceed the greater of—

''(i) 2 times the amount of such economic damages so awarded, or

''(ii) $250,000; and

''(B) in a case in which 2 times the amount of the economic damages awarded as monetary compensatory relief is greater than $250,000, may not exceed $500,000.

''(2) APPLICATION TO DECISIONS INVOLVING MEDICAL NECESSITY AND MEDICAL JUDGMENT.—This subsection and subsection (a)(10) apply only with respect to final decisions described in section 103(a)(2) of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(3) DEFINITIONS.—For purposes of this subsection and subsection (a)(10)—

''(A) GROUP HEALTH PLAN; HEALTH INSURANCE ISSUER; HEALTH INSURANCE COVERAGE.—The terms 'group health plan', 'health insurance issuer', and 'health insurance coverage' shall have the meanings provided such terms under section 733, respectively.

''(B) FINAL DECISION.—The term 'final decision' means, with respect to a group health plan, the final decision of the plan under section 102 of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(C) PERSONAL INJURY.—The term 'personal injury' means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain, and includes a physical injury arising out of a failure to treat a mental illness or disease.

''(D) CLAIM FOR BENEFITS.—The term 'claim for benefits' has the meaning provided in section 101(f)(1) of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(E) FAILURE TO EXERCISE ORDINARY CARE.—The term 'failure to exercise ordinary care' means a negligent failure to provide—

''(i) the consideration of appropriate medical evidence, or

''(ii) the regard for the health and safety of the participant or beneficiary,

that a prudent individual acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with same or similar circumstances.

''(4) EXCEPTION FOR DENIALS IN ACCORDANCE WITH RECOMMENDATION OF EXTERNAL APPEAL ENTITY.—No person shall be liable under subsection (a)(10) for additional monetary compensatory relief described in paragraph (1) in any case in which the denial referred to in subsection (a)(10) is upheld by the recommendation of an external appeal entity issued with respect to such denial under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999.

''(5) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), subsection (a)(10) does not authorize—

''(i) any cause of action against an employer or other plan sponsor maintaining a group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

''(ii) a right of recovery or indemnity by a person against such an employer or sponsor (or such an employee) for relief assessed against the person pursuant to a cause of action under subsection (a)(10).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action under subsection (a)(10) commenced against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment), if—

''(i) such action is based on the direct participation of the employer or sponsor (or employee) in the sole final decision of the plan referred to in paragraph (2) with respect to a specific participant or beneficiary on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the decision on the claim resulted in personal injury to, or the wrongful death of, such participant or beneficiary.

''(C) DIRECT PARTICIPATION.—For purposes of this subsection, in determining whether an employer or other plan sponsor (or employee of an employer or other plan sponsor) is engaged in direct participation in the sole final decision of the plan on a claim under section 102 of the Bipartisan Consensus Managed Care Improvement Act of 1999, the employer or plan sponsor (or employee) shall not be construed to be engaged in such direct participation solely because of any form of decisionmaking or conduct, whether or not fiduciary in nature, that does not involve the final decision with respect to a specific claim for benefits by a specific participant or beneficiary, including (but not limited to) any participation in a decision relating to:

''(i) the selection or retention of the group health plan or health insurance coverage involved or the third party administrator or other agent, including any related cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(ii) the creation, continuation, modification, or termination of the plan or of any coverage, benefit, or item or service covered by the plan affecting a cross-section of the plan participants and beneficiaries;

''(iii) the design of any coverage, benefit, or item or service covered by the plan, including the amount of copayments and limits connected with such coverage, and the specification of protocols, procedures, or policies for determining whether any such coverage, benefit, or item or service is medically necessary and appropriate or is experimental or investigational;

''(iv) any action by an agent of the employer or plan sponsor (other than an employee of the employer or plan sponsor) in making such a final decision on behalf of such employer or plan sponsor;

''(v) any decision by an employer or plan sponsor (or employee) or agent acting on behalf of an employer or plan sponsor either to authorize coverage for, or to intercede or not to intercede as an advocate for or on behalf of, any specific participant or beneficiary (or group of participants or beneficiaries) under the plan; or

''(vi) any other form of decisionmaking or other conduct performed by the employer or plan sponsor (or employee) in connection with the plan or coverage involved, unless the employer makes the sole final decision of the plan consisting of a failure described in paragraph (1)(A) as to specific participants or beneficiaries who suffer personal injury or wrongful death as a proximate cause of such decision.

''(6) REQUIRED DEMONSTRATION OF DIRECT PARTICIPATION.—An action under subsection (a)(10) against an employer or plan sponsor (or employee thereof) for remedies described in paragraph (1) shall be immediately dismissed—

''(A) in the absence of an evidentiary demonstration in the complaint of direct participation by the employer or plan sponsor (or employee) in the sole final decision of the plan with respect to a specific participant or beneficiary who suffers personal injury or wrongful death,

''(B) upon a demonstration to the court that such employer or plan sponsor (or employee) did not directly participate in the final decision of the plan, or

''(C) in the absence of an evidentiary demonstration that a personal injury to, or wrongful death of, the participant or beneficiary resulted.

''(7) TREATMENT OF THIRD-PARTY PROVIDERS OF NONDISCRETIONARY ADMINISTRATIVE SERVICES.—Subsection (a)(10) does not authorize any action against any person providing nondiscretionary administrative services to employers or other plan sponsors.

''(8) REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

''(A) IN GENERAL.—Subsection (a)(10) applies in the case of any cause of action only if all remedies under section 503 (including remedies under sections 102 and 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 made applicable under section 714) with respect to such cause of action have been exhausted.

''(B) EXTERNAL REVIEW REQUIRED.—For purposes of subparagraph (A), administrative remedies under section 503 shall not be deemed exhausted until available remedies under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 have been elected and are exhausted.

''(C) CONSIDERATION OF ADMINISTRATIVE DETERMINATIONS.—Any determinations under section 102 or 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 made while an action under subsection (a)(10) is pending shall be given due consideration by the court in such action.

''(9) SUBSTANTIAL WEIGHT GIVEN TO EXTERNAL REVIEW DECISIONS.—In the case of any action under subsection (a)(10) for remedies described in paragraph (1), the external review decision under section 103 shall be given substantial weight when considered along with other available evidence.

''(10) LIMITATION OF ACTION.—Subsection (a)(10) shall not apply in connection with any action commenced after the later of—

''(A) 1 year after (i) the date of the last action which constituted a part of the failure, or (ii) in the case of an omission, the latest date on which the fiduciary could have cured the failure, or

''(B) 1 year after the earliest date on which the plaintiff first knew, or reasonably should have known, of the personal injury or wrongful death resulting from the failure.

''(11) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by the fiduciary which consists of full compliance with the reversal under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 of a denial of a claim for benefits.

''(12) CONSTRUCTION.—Nothing in this subsection or subsection (a)(10) shall be construed as authorizing an action—

''(A) for the failure to provide an item or service which is not covered under the group health plan involved, or

''(B) for any action taken by a fiduciary which consists of compliance with the reversal or modification under section 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 of a final decision under section 102 of such Act.

''(13) PROTECTION OF MEDICAL MALPRACTICE UNDER STATE LAW.—This subsection and subsection (a)(10) shall not be construed to preclude any action under State law not otherwise preempted under this section or section 503 or 514 with respect to the exercise of a specified professional standard of care in the provision of medical services.

''(14) REFERENCES TO THE BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999.—Any reference in this subsection to any provision of the Bipartisan Consensus Managed Care Improvement Act of 1999 shall be deemed a reference to such provision as in effect on the date of the enactment of such Act.

''(o) EXPEDITED COURT REVIEW.—In any case in which exhaustion of administrative remedies in accordance with section 102 or 103 of the Bipartisan Consensus Managed Care Improvement Act of 1999 otherwise necessary for an action for injunctive relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by clear and convincing evidence that such exhaustion is not reasonably attainable under the facts and circumstances without any further undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain such relief. Any determinations which already have been made under section 102 or 103 in such case, or which are made in such case while an action under this paragraph is pending, shall be given due consideration by the court in any action under this subsection in such case.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the date of the enactment of this Act.

SEC. 304. AVAILABILITY OF BINDING ARBITRATION.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this Act) is amended further by adding at the end the following new subsection:

''(p) BINDING ARBITRATION PERMITTED AS ALTERNATIVE MEANS OF DISPUTE RESOLUTION.—

''(1) IN GENERAL.—This subsection shall apply with respect to any adverse coverage decision rendered under a group health plan under section 102 or 103, if—

''(A) all administrative remedies under section 503 required for an action in court under this section have been exhausted,

''(B) under the terms of the plan, the aggrieved participant or beneficiary may elect to resolve the dispute by means of a procedure of binding arbitration which is available with respect to all similarly situated participants and beneficiaries (or which is available under the plan pursuant to a bona fide collective bargaining agreement pursuant to which the plan is established and maintained), and which meets the requirements of paragraph (3), and

''(C) the participant or beneficiary has elected such procedure in accordance with the terms of the plan.

''(2) EFFECT OF ELECTION.—In the case of an election by a participant or beneficiary pursuant to paragraph (1)—

''(A) decisions rendered under the procedure of binding arbitration shall be binding on all parties to the procedure and shall be enforceable under the preceding subsections of this section as if the terms of the decision were the terms of the plan, except that the court in an action brought under this section may vacate any award made pursuant to the arbitration for any cause described in paragraph (1), (2), (3), (4), or (5) of section 10(a) of title 9, United States Code, and

''(B) subject to subparagraph (A), such participant or beneficiary shall be treated as having effectively waived any right to further review of the decision by a court under the preceding subsections of this section.

''(3) ADDITIONAL REQUIREMENTS.—The requirements of this paragraph consist of the following:

''(A) ARBITRATION PANEL.—The arbitration shall be conducted by an arbitration panel meeting the requirements of paragraph (4).

''(B) FAIR PROCESS; DE NOVO DETERMINATION.—The procedure shall provide for a fair, de novo determination.

''(C) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to the arbitration procedure—

''(i) may submit and review evidence related to the issues in dispute;

''(ii) may use the assistance or representation of one or more individuals (any of whom may be an attorney); and

''(iii) may make an oral presentation.

''(D) PROVISION OF INFORMATION.—The plan shall provide timely access to all its records relating to the matters under arbitration and to all provisions of the plan relating to such matters.

''(E) TIMELY DECISIONS.—A determination by the arbitration panel on the decision shall—

''(i) be made in writing;

''(ii) be binding on the parties; and

''(iii) be made in accordance with the medical exigencies of the case involved.

''(4) ARBITRATION PANEL.—

''(A) IN GENERAL.—Arbitrations commenced pursuant to this subsection shall be conducted by a panel of arbitrators selected by the parties made up of 3 individuals, including at least one physician and one attorney.

''(B) QUALIFICATIONS.—Any individual who is a member of an arbitration panel shall meet the following requirements:

''(i) There is no real or apparent conflict of interest that would impede the individual conducting arbitration independent of the plan and meets the independence requirements of subparagraph (C).

''(ii) The individual has sufficient medical or legal expertise to conduct the arbitration for the plan on a timely basis.

''(iii) The individual has appropriate credentials and has attained recognized expertise in the applicable medical or legal field.

''(iv) The individual was not involved in the initial adverse coverage decision or any other review thereof.

''(C) INDEPENDENCE REQUIREMENTS.—An individual described in subparagraph (B) meets the independence requirements of this subparagraph if—

''(i) the individual is not affiliated with any related party,

''(ii) any compensation received by such individual in connection with the binding arbitration procedure is reasonable and not contingent on any decision rendered by the individual,

''(iii) under the terms of the plan, the plan has no recourse against the individual or entity in connection with the binding arbitration procedure, and

''(iv) the individual does not otherwise have a conflict of interest with a related party as determined under such regulations as the Secretary may prescribe.

''(D) RELATED PARTY.—For purposes of subparagraph (C), the term 'related party' means—

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

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

''(iii) the institution at which the medical care involved in the coverage decision is provided,

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

''(v) any other party determined under such regulations as the Secretary may prescribe to have a substantial interest in the coverage decision .

''(E) AFFILIATED.—For purposes of subparagraph (C), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(5) ALLOWABLE REMEDIES.—The remedies which may be implemented by the arbitration panel shall consist of those remedies which would be available in an action timely commenced by a participant or beneficiary under section 502, taking into account the administrative remedies exhausted by the participant or beneficiary under section 503.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to adverse coverage decisions initially rendered by group health plans on or after the date of the enactment of this Act.

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

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

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

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

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

and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the requirements of title I of the Bipartisan Consensus Managed Care Improvement Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2000 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

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

(B) the general effective date.

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

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

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

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

TITLE VI—HEALTH CARE PAPERWORK SIMPLIFICATION

SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Bipartisan Consensus Managed Care Improvement Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

The CHAIRMAN. Pursuant to House Resolution 323, the gentleman from New York (Mr. HOUGHTON) and the gentleman from Michigan (Mr. DINGELL) will each control 30 minutes.

The Chair recognizes the gentleman from New York (Mr. HOUGHTON).

Mr. HOUGHTON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I, together with my colleagues the gentleman from South Carolina (Mr. GRAHAM), the gentleman from Tennessee (Mr. HILLEARY) and the gentleman from Nevada (Mr. GIBBONS) rise to offer an amendment in the nature of a substitute to the Norwood-Dingell bill, and I will make this really quite short, this introduction of mine. I am an original cosponsor of the Norwood-Dingell bill.

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I absolutely support what it is trying to do. It is thoughtful; it corrects a wrong which has been around since the beginning of the health maintenance organizations. And all three gentlemen who are supporting this and promoting it are superb legislators and believers in health care reform.

But I have only one problem with the bill in that what it does, it slides over another very, very important issue. What it does, frankly, is to open a huge gap for those who are simply providing the money to fund these plans.

So while supporting the concept and the aim of the Norwood-Dingell bill, because of this huge void in funding, we almost surely will, in effect, be hurting the people we are trying to help. And I say this autobiographically from my experience in the business field.

So I think it is irresponsible for us to ignore this issue in this great wave of enthusiasm for this bill. Despite the emotions of the day, if we do not do something, and I feel that it will be appropriate through our amendment, it will come back to haunt us.

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

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentleman from New Jersey (Mr. ANDREWS).

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

Mr. ANDREWS. Mr. Chairman, I rise in opposition to this well-intentioned but, I think, flawed substitute. There are three deficiencies in the substitute which I believe compel its rejection and the adoption of the underlying Norwood-Dingell-Ganske bill.

First is that this substitute usurps States' rights and States' causes of action with respect to tort law. One of the pieces of wisdom of the regulatory system in the United States is that different States have the authority to set different standards of care and different causes of action according to their State law. Each of our several States is very different. There are different needs of the people, there are different legal problems, and we recognize this by recognizing the fact that tort law causes of action typically, and

sometimes exclusively, come from State law.

This substitute creates one single Federal cause of action, and I believe that one-size-fits-all approach is inappropriate to solving the problem that is before us.

The second defect is that this substitute does not provide full relief for people who are wronged. The limitation on damages is a very meaningful limitation on damages. For example, by tying the limitation to a multiple of economic damages, what about the case of a person who is a stay-at-home parent who does not have a job that pays in remuneration, but pays in psychic rewards, and that person is severely harmed by the actions of a managed care company. The damages that person would be able to recover would be significantly limited by this amendment, and I believe that is another reason for its rejection.

Finally, the cause of action has some technical flaws in it which could exclude some managed care decision-makers from accountability. By creating the requirement that the decision-maker both have the authority to make the final decision and exercise that authority, there are certain decision-makers and certain decisions which would be exempt from accountability under this process.

So although I congratulate the author for frankly offering a substitute that moves much closer in the direction of the underlying bill, I believe for these three reasons it should be rejected; and I urge the defeat of the substitute.

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN. The Chair would ask Members to refrain from using cell phones and other telecommunications devices on the floor of the House.

Mr. HOUGHTON. Mr. Chairman, I yield 5 minutes to the gentleman from South Carolina (Mr. GRAHAM), my great friend.

Mr. GRAHAM. Mr. Chairman, I thank the gentleman for yielding me this time. I would like to say I have thoroughly enjoyed working with the gentleman from New York (Mr. HOUGHTON) and the other two Members who are Norwood-Dingell cosponsors on trying to bring some common sense reform to a very important issue.

Where are the American people? The American people, whether one is Republican or Democrat alike, believe HMOs should be sued when they hurt people. The American people believe one should be able to choose one's own doctor even if one has to pay more money out of their own pocket. The American people believe that one should not have to call the insurance company before one can take a kid to the emergency room, and they should not be able to deny treatment and payment because one did not call them.

The American people are very much for a lot of the reforms in this bill. The American people are also for limiting our tort system in a way that keeps people in business. The American people are very much for common sense legal reform. That is what this bill does.

Here is the question of the 29 Republicans who have voted ''no,'' and here is the question to the Democratic Party: What if we kept the health care in Norwood-Dingell the same? What if we did not change it one word? What if we gave all of the patient protections that Norwood-Dingell give the American people? What would my colleagues do if we asked them to move a little bit toward the American business community by giving them a chance to keep their employees with health care in the area of liability?

My question is, can we tear down the legal wall that unfairly protects HMOs from liability and keep people in the health care business? Yes, we can, if people will work together. The answer will be no if we continue on this confrontational track.

What do we do differently? We do nothing different in health care. Here is what we do in liability. I address my friend, the gentleman from New Jersey (Mr. ANDREWS), and his comments. We keep it at the Federal level. Do my colleagues know why we keep it at the Federal level? Because uniformity is helpful in controlling costs.

ERISA is a Federal law that protects employees' retirement benefits. If one has a claim under ERISA for one's retirement, one does not go to 50 different States. We do not let 50 different States write 401K plans. One goes to Federal court, and one has their day in Federal court because it is a Federal law that is uniform to make sure employers who do business in more than one State can have one set of rules to live by so that they know the rules of the road. We give a uniform forum to the people who may be aggrieved, and we give them a fair day in Federal court.

Mr. Chairman, I say to my colleagues, if Norwood-Dingell passes the way it is today, here is what is going to happen in corporate America. If one can be sued as a multi-State business in 50 different States with 50 different legal theories of holding people accountable in the health care industry, we are going to have lawyers meet with the corporate board and say, you are going to be chasing jury verdicts all over this country. Get out of this business. This is voluntary on your part; you do not have to do it.

You are going to spend more time in State court on lawyer fees than you are going to spend on health care. If we allow 50 different theories of being sued, we are going to not only tumble down the liability wall, we are going to tumble down the benefits that go to the people who need it the most, and that is the employees.

What do we do in this bill? We limit damages in two areas. Economic damages are fully recovered.

Let me say this to the gentleman from New Jersey (Mr. ANDREWS). I have represented housewives, people who do not have the traditional job. Let me tell my colleague, if we put down what it cost to run a family, we can add up some serious damages, because people who stay at home and take care of families have a job, and we can turn that into money as a lawyer, because I have done it. One can get one's full range of damages under this bill, but we are not going to let people make up numbers called pain and suffering beyond a half a million dollars to keep people in business.

Punitive damages are taken off the table. If we leave that as a form of damages, the cost of premiums are going to go through the roof. Punitive damages helps no one have a better quality of life except the lawyer who puts the money in their pocket, and I have been a lawyer seeking punitive damages.

Mr. Chairman, we can have common sense legal reform that gives people a fair day in court, that allows businesses to be sued, but in a uniform manner with a national standard so that they do not get out of this business chasing 50 different juries.

If we want to help patients keep the health care the same, if we want to help business, give them a chance to understand the rules of the road no matter where they do business; give them some commonsense legal protection so that they do not get sued to death.

Mr. Chairman, this bill as currently written is going nowhere. With some common sense changes, it can become the law of the land and people can have the health care they deserve and paid for; they can have their day in court, and people like the gentleman from New York (Mr. HOUGHTON) who have been in business and offered employee benefits can continue to do that if we will work together.

Mr. BROWN of Ohio. Mr. Chairman, I yield 4 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I indeed thank the gentleman for yielding me this time, and I would like to take a moment to talk about the gentleman from New York (Mr. HOUGHTON) and the gentleman from South Carolina (Mr. GRAHAM), not only two good friends, but two cosponsors of our bill, and I want both of them to know how much I appreciate the work they have done with us. The gentleman from New York (Mr. HOUGHTON) knows that we have spent many hours trying to, within our bill, reach accommodation with him.

I will just submit for the RECORD a CRS report that agrees that the changes that he has worked so hard to get in our bill we were able to do that and accommodate him.

CONGRESSIONAL RESEARCH SERVICE,
LIBRARY OF CONGRESS,
Washington, DC, October 5, 1999.

To: Hon. Charlie Norwood, Attention: Rodney Whitlock.

From: Kimberly D. Jones, Legislative Attorney, American Law Division.

Subject: Legal Analysis of Whether the Amendment in the Nature of a Substitute To H.R. 2723 offered by Representatives Norwood, Dingell, Ganske and Berry Addresses Concern Raised by Representative Houghton.

This memorandum is in response to your request for a legal opinion whether concerns raised in regard to H.R. 2723 by Representative Houghton in a document provided by your office have been addressed by a substitute amendment being offered by Representatives Norwood, Dingell, Ganske and Berry (Substitute Amendment). H.R. 2723 would amend Section 514 of ERISA to prevent ERISA's preemption provision from interfering with a state law that seeks to recover damages for personal injury or wrongful death resulting from acts connected to or arising out of an arrangement regarding ''the provision of insurance, administrative services, or medical services'' by a group health plan. In addition, the bill establishes standards of internal review and creates an external review process. Under the bill, no punitive damages may be awarded if the defendant complied with external review in a timely manner, as defined under the bill. It bars from review those decisions denying coverage for items specifically excluded from the plan.

In a document provided by your office, Representative Houghton raises a number of concerns with H.R. 2723. The first concern is that the liability clause in Section 302(a)(1) of H.R. 2723 shows ''no connection between wrongdoing and who is sued.'' Section 302(a)(1) states:

(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan . . ., or

(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

Specifically, Representative Houghton's letter expresses concern about the potentially broad definition of the term ''any person'' and the potential activities that could be grounds for a cause of action under the bill. Representative Houghton also expresses concern about the bill permitting a suit based on any act of the plan, whether ''good or bad.''

The language of section 302(a)(1) is the same in both H.R. 2723 and the substitute amendment. Therefore, both would allow claims under state law. The potential parties to a suit and the basis of a suit would be determined by state law. Ultimately, the participant or beneficiary would have to satisfy the elements of a state law claim and meet the standard of proof required to prevail under state law.

Another concern raised by Representative Houghton is that state law may not provide an adequate remedy. Currently, many states have laws that allow only a ''natural person'' to be licensed as a doctor or to practice medicine. As a result, many states prohibit a corporation or similar professional entity from giving medical advice or practicing medicine.[1] In states where these corporate practice of medicine laws exist, HMOs (and other managed care plans) are legally prohibited from and are not considered to be practicing medicine or making medical decisions, even if they contract with licensed physicians to perform services on their behalf and/or make benefit decisions that affect the doctor's treatment. These laws could present an obstacle to HMO enrollees who seek to sue their HMO for medical malpractice or negligence. However, other state claims that do not address the standards for practicing medicine could be brought, i.e., negligent processing of a benefit, or ''bad faith'' denials. It should also be noted that some states have acted to remove the shield that managed care plans have against state medical malpractice claims. Texas, California and Missouri have enacted laws that would give patients the right to sue their managed care plan for injuries resulting from acts of the plan.

Another issue raised by Representative Houghton is that H.R. 2723 would allow an individual to go to court without exhausting internal and external review. H.R. 2723 states:

(3) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is not required to exhaust administrative processes [internal and external review] . . . where the injury to or death of such individual has occurred before completion of such processes.

The language of the substitute amendment states:

(e) FUTILITY OF EXHAUSTION.—An individual bringing an action under this subsection is required to exhaust administrative processes [internal and external review] . . ., unless the injury to or death of such individual has occurred before the completion of such processes.

The substitute amendment clarifies the language of H.R. 2723 to require a participant or beneficiary to exhaust internal and external review before commencing an action under state law, unless the injury or death has already occurred.

The final concern raised in the letter is the possibility that an employer may be liable for under H.R. 2723 for ''any exercise of discretionary authority including hiring the insurance company.'' Under H.R. 2723, no cause of action may be brought against an employer or plan sponsor (or its employees) which provides a group health plan. This provision also expressly prohibits a person from seeking indemnification from the employer or plan sponsor (or its employees) for damages awarded under the Act. However, the bill also includes an exception to these provisions where the employer or plan sponsor (or its employees) exercised its discretionary authority to make a benefits decision and the decision resulted in harm. The exercise of discretionary authority does not include the decision to include or exclude certain benefits from the plan, to provide extra-contractual benefits, or a decision not to provide a benefit while internal or external review is being conducted. The bill does not permit a cause of action under state law for failing to provide a benefit or service that is not covered by the plan.

Under H.R. 2723, it is possible that an employer who has a self-insured plan could be liable under a state cause of action. If the employer in the administration of the plan or the provision of benefits uses discretionary authority to make a benefits decision, it would fall under the exception to the employer protection provision of the bill. This is more likely to happen if the employer chooses to administer the plan itself. If the employer contracts with an insurance company to provide these benefits, the bill could be used to protect the employer if it did not exercise discretionary authority on a claims decision. It is less likely than an employer would be directly involved if the administration of the plan has been contracted to an insurance company. However, if the employer becomes involved in a claims decision it would be liable. Also, it could be argued that, although the insurance company made the decision, the company is an agent of the employer and acting on the employer's behalf. As the employer's agent, the argument could be made that the actions of the insurance company could be imputed to the employer. It is not clear if this argument would be successful.

The language of the employer provision in the substitute amendment is similar to H.R. 2723, except the term ''group health plan'' is included in the category of parties that may not be sued under this Act. The provision states, [Section 302(a)] ''does not authorize—(i) any cause of action against a group health plan or an employer or other plan sponsor maintaining the plan, or (i) a right to recovery, indemnity, or contribution by a person against a group health plan or an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under [Section 302(a)(1)]. The term ''group health plan'' is also included in the exception to the employer provision which states:

Subparagraph (A) shall not preclude any cause of action described in [Section 302(a)] against [a] group health plan or an employer or other plan sponsor (or against an employee of such a plan, employer, or sponsor acting within the scope of employment) if—(i) such action is based on the exercise by the plan, employer, or sponsor (or employee of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and (ii) the exercise by the plan, employer, or sponsor (or employee) of such authority resulted in personal injury or wrongful death.

The inclusion of the term ''group health plan'' would clarify the bill's application to fully-insured plans. The term ''group health plan'' is defined under ERISA as ''an employee welfare benefit plan to the extent that the plan provides medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement, or otherwise.''[2] Therefore the employer provision would protect a group health plan from liability, unless it exercised discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue.

In a fully-insured plan, a company will contract with an insurance company to provide coverage for its employees. This company is known as a ''health insurance issuer'' under ERISA. The term ''health insurance issuer'' is defined under ERISA as ''an insurance company, insurance service, or insurance organization 9including a health maintenance organization . . .) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance. . . . Such term does not include a group health plan.''[3] In essence, in the case of a fully-insuredd plan, the plan and the health insurance issuer are two distinct entities. By including group health plans in the employer exception and special rule provisions of the substitute amendment, it is unlikely that the actions of the health insurance issuer will be imputed to the plan. However, a fully-insured plan

[1] Footnotes at the end of article.

could face liability if it exercises discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue.

In the case of a self-insured plan, the result is the same under both H.R. 2723 and under the substitute amendment. Where the employer assumes the risk of providing health insurance to its employees, the employer and the plan are for practical purposes the same. As such the acts of a self-insured plan could subject the employer to liability due to the high probability that the employer will have and use discretionary authority to make a decision on a claim for benefits covered under the plan or coverage in the case at issue.

KIMBERLY D. JONES,
Legislative Attorney.

FOOTNOTES

[1] D. Cameron Dobbins, *Survey of State Laws Relating to the Corporate Practice of Medicine*, 9 Health Lawyer 18 (1997). Approximately 15 states have corporate practice of medicine laws.

[2] 29 U.S.C.A. § 1191b(a) (West Supp. 1999).

[3] 29 U.S.C.A. § 1191b(b)(2).

The Houghton amendment would make insurers liable in Federal court rather than State court. That is sort of the bottom line. H.R. 2723 and every bill, incidentally, I have introduced on liability ensures we want them to face State liability.

I would just like my colleagues to consider a thought, consider this quote from Chief Justice William Rehnquist, and he says, and I quote, ''Congress should commit itself to conserving the Federal courts as a distinctive judicial forum of limited jurisdiction in our system of Federalism. Civil and criminal jurisdictions should be assigned to the Federal courts only to further clearly define and justify national interests, leaving to the State courts the responsibility for adjudicating all other matters.''

Should HMO liability be considered a national interest warranting Federal jurisdiction?

In the Federal courts today, there are 65 vacancies and the courts anticipate another 16 vacancies forthcoming. Twenty-two courts are considered to be emergency status, under emergency status. They do not have appropriate coverage from the bench to consider the cases before them. To this situation we are going to add a new Federal tort?

The Speedy Trial Act of 1974 requires the Federal bench to give priority to criminal cases over civil cases. In 1998, criminal case filings were up 15 percent. A single mother whose child needs constant care because of a decision made by an HMO will have to stand in line behind all of the drug dealers before she can try to hold the HMO liable for its action.

State courts are easier for patients to access. Almost every town in America has a State court. Federal courts are few and far between. States like Texas and Georgia and California already have moved to make insurers accountable for their actions. State courts are a more appropriate and accessible venue for personal injury and wrongful death.

Considering the problems that patients will have in accessing Federal court, it is hard to imagine that HMO liability meets the Chief Justice's definition of a national interest. It certainly does not meet the single mother's definition.

Like all politics, all health care really is local. H.R. 2723 holds insurers liable for their decisions that harm or kill someone in the most appropriate venue: State courts.

□ 1500

My dear friend, and I do mean that sincerely, my dear friend, the gentleman from South Carolina (Mr. GRAHAM), he knows Frogmore, South Carolina, is a long way from a Federal court. You just cannot get there from here. We just need to do this at home. We also need to consider that the companies that do have a business in all 50 States, my goodness, they have to deal with 50 States now. Because you have a business in all 50 States does not preempt you from ever going into State court.

What about slip and fall? That happens every day. They have to be ready in every State. I am not even going to ask Members to vote against my friends, just vote for H.R. 2723 intact on the next vote.

Mr. Chairman, I include for the RECORD the following statement on physician pathology services:

It is the intent of this legislation that the access to care subtitle apply to clinical pathology and specialized clinical pathology services. However, I am aware that the language may not be specific enough on this particular issue. Therefore, when we go to conference with the Senate, I am willing to work to further clarify this issue by including clarifying language on access to clinical pathology and specialized clinical pathology services in sections 111 and 112 of this legislation

It is the intent of this legislation that the access to care subtitle apply in the same manner to clinical pathology and specialized clinical pathology services as it would to other specialty medical services in this legislation.

It is my intention that when we go to conference with the Senate that I will work to further clarify this issue by including explicit language on access to clinical pathology and specialized clinical pathology services in section 114 of the legislation.

CHARLIE NORWOOD.

Mr. HOUGHTON. Mr. Chairman, I yield 1½ minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, I appreciate those kind comments from my friend across the river in Georgia. We agree on most everything.

One thing I am not going to do when this is over, go practice dentistry. I promise the Members that today. I appreciate all these doctors wanting to rewrite this liability section, but let me ask one question of my friends on the other side. Are they suggesting that if a fiduciary mismanages the retirement benefits of a company or employees, that they should be sued in State court? Is that what they are telling us?

Under current law under ERISA, if there is a mismanagement by the fiduciary of the employees' retirement benefits, is it the gentleman's belief that State court is the proper place to sue?

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. GRAHAM. I yield to the gentleman from Georgia.

Mr. NORWOOD. The gentleman wins. I am not a lawyer. I am not sure. I just know when one has liability under our bill, it has to be in State court.

Mr. GRAHAM. The reason the gentleman cannot answer the question, Mr. Chairman, if we had that as a rule, every 401(k) plan in America would fold, because nobody in their right mind is going to offer these benefits so they can be sued in 50 States under 50 different theories of plan management.

The reason we have this law at the Federal level is to encourage employers to offer health care and retirement benefits so they know what the rules are, and they cannot be nickeled and dimed in every State.

This is an emotional topic from the plaintiff's point of view and from the business point of view. If Members want to destroy health care, allow 50 different theories of liability. People are going to get out of the business.

Mr. HOUGHTON. Mr. Chairman, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Chairman, the Commission on Health Care Dispute Resolution, formed by the American Bar Association, the American Medical Association, and the American Arbitration Association, issued a draft report in 1998 recommending the use of alternative dispute resolutions for medical insurance disputes.

The Houghton-Graham substitute amendment allows this, using binding arbitration as an alternative option for a patient to appeal the decisions of their health insurers, and follows the standards set by the commission, which include independent and impartial arbitrators with sufficient medical or legal expertise, appropriate credentials, and who have no conflicts of interest.

Additionally, the arbitration process must include a fair de novo determination, the opportunity to submit evidence, have representation, and make oral presentation. The health insurer must also provide all records and provisions of the plan relating to the matter.

Arbitration is a voluntary option to operate in lieu of court. Some people just do not want to go to court. Because arbitration is voluntary for the patient to choose, it will not take away from the patient's right to sue in court, but instead, adds a choice to the accountability process. I think we should expand choice for patients who are harmed by wrongful decisions. The Norwood-Dingell bill does not offer this choice.

Mr. Chairman, I urge Members to support the Houghton-Graham substitute.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, we have indeed been making history since we started this debate last evening. Americans do not have to wait for their State to catch up in protecting them when they become ill, in protecting their interests. If there is hurt, then HMOs are going to have to withstand the scrutiny that doctors and hospitals withstand right now.

I applaud the efforts of the gentleman from New York (Mr. HOUGHTON). There are a tremendous amount of similarities between what he wants to do and what is in the Dingell-Norwood bill, no doubt about it. I detect, if I may, and I hear the fears portrayed by my good friend, the gentleman from South Carolina (Mr. LINDSEY), from the proponents of this substitute.

But I also hear the fears and the anxiety of actual human beings who have to deal with the bureaucratic maze that is in front of them when they are ill. If I have to err, if I have to make a mistake, I believe, in good faith, we should make it on the side of the patient.

What that means is that all the things that we agree upon in similar pieces of legislation should not be shortstopped because we cannot agree on where that limit is if one has to go to court. There are built-in processes right within this legislation internally that protect us from those fears and those anxieties which Members have expressed.

That is why I cannot vote for this substitute, but I applaud the gentleman's efforts.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California (Ms. PELOSI).

Ms. PELOSI. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I rise in opposition to the Houghton-Graham substitute and in support, strong support, of the Dingell-Norwood legislation. I commend both of those gentlemen for their courageous leadership.

Nothing, I think, speaks more eloquently to the need for their proposal than the case of my constituent, Stephen Parrino, from San Francisco. Stephen was diagnosed with a brain tumor. His HMO referred him to Loma Linda Medical Center, which successfully removed the tumor.

Stephen's treating physician then ordered him to undergo proton beam therapy no later than 2 or 3 weeks following the operation, but Stephen's HMO refused to pay for the therapy, saying that it was experimental, unapproved, and not medically necessary. For those reasons, it did not fall within the managed care guidelines.

After repeated calls to the claims reviewer, Stephen was told that the HMO would ask for a second opinion. Seven weeks after surgery was completed, the second opinion came back. It was medically necessary. But it was now too late. Two weeks later, Stephen was informed his brain tumor had spread; it had reoccurred to the same place, and spread to the rest of his body, including his lungs. He subsequently brought suit against the HMO in State court, but claiming ERISA preemption, the HMO had the action removed to the U.S. District Court, which dismissed his case. With no remedy against the HMO, Stephen Parrino ultimately died as a result of the tumor.

Mr. Chairman, this story has been told over and over again in our country, of desperately sick people who thought they had access to the best health care in the world, and who find themselves at the mercy of the managed care bureaucrats in a judicial system that provides them with less assistance than they need and no compensation after the damage has been done.

We have a responsibility to stop this. Health care consumers must be able to hold their health care plans accountable and get lifesaving care. That is why the American Psychological Association writes that the Norwood-Dingell bill is the only legislation that holds HMOs accountable for negligent acts.

Mr. Parrino's HMO did not provide him with the remedy to save his life. His family has no remedy against that HMO.

Mr. HOUGHTON. Mr. Chairman, I yield 1 minute to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, I would like to address the case previously mentioned on the floor. It is a very emotional topic.

Under our bill, they would have a legal remedy. They would have a wrongful death claim brought in Federal court. They would get a full range of what has been lost: the future wages, past wages, past medical bills, the entire package that goes with a wrongful death claim, plus a half a million dollars for pain and suffering, which in a wrongful death claim is very hard to get anyway. They would get that whole range. The liability wall would come down.

Let me just make this one statement. I am asking every member of this House who has voted for products liability reform, where we limit damages, just like we do here, to ask themselves, are they being honest with themselves? What is the deal, here? If someone gets hurt by a machine, we are entitled to limit damages, but if they get hurt by an HMO, for some strange reason and they go through the roof, 280 people in this House have voted for liability reform just like we have today, including the gentleman from Iowa (Mr. GANSKE) and including the gentleman from Georgia (Mr. NORWOOD).

They were willing to limit damages then, but not now. Why?

Mr. HOUGHTON. Mr. Chairman, I yield 4 minutes to the gentleman from Tennessee (Mr. HILLEARY).

Mr. HILLEARY. Mr. Chairman, I am proud to be in the House today as a coauthor and principle cosponsor of this legislation, the Houghton-Graham-Hilleary-Gibbons substitute to the Norwood-Dingell bill.

Our substitute would clarify and close the loopholes that presently exist, in our opinion, in the liability section of the base bill before us. I, like the drafters of the base bill, do believe that some sort of accountability mechanism must exist in order to improve today's managed care plans. I support holding managed care plans that make negligent decisions accountable in a court of law.

However, the bill ignores to a serious level, I believe, concerns about the potential liability that employers will face. This problem must be resolved or literally millions more Americans will join the ranks of the uninsured.

I know that adding millions of Americans to the ranks of the uninsured is absolutely not the intent of anybody on the other side, or who supports the Norwood-Dingell bill. They do not mean to expose innocent employers to liability, I am quite sure. However, the language they use to protect the employers does not achieve their goal, and therefore, we will try to correct it in our substitute.

Under the base bill, a business cannot be sued if they use discretionary authority in making coverage decisions. The problem is that the phrase ''discretionary authority'' is, in my opinion, much too broad.

Let us first guess what is meant by ''discretionary authority.'' What if an employer sets up a clerical system that simply provides information on coverage decisions? Can that employer be sued under the base bill? Yes, it could be, under discretionary authority.

What if a plan simply selects a third-party administrator or a certain type of health care plan. Can they be sued? Yes, under discretionary authority.

What if an employer reverses the decision of a plan on behalf of an employee? Could they be sued? Shockingly, possibly, yes, under the phrase ''discretionary authority.'' It is too broad.

With discretionary authority, we are, in reality, creating a system where lawyers can find loopholes to go after innocent companies. We cannot accept such loopholes that allow innocent businesses to be dragged into court just because they have the deepest pocket, which in turn incentivizes businesses to drop health care policies for their employees.

Our substitute plugs this loophole. Under this substitute, only the business that has direct participation in making the sole, final decision of the plan is liable. Those are the key words, ''Sole and final decision.'' The loophole is closed. This will force the people in

charge of the plan to make a good decision or be on the wrong end of monetary damages.

Meanwhile, innocent employers, which had nothing to do with the decision on health care, will not be forced into court, as is the case with the base bill.

I truly commend the gentleman from Michigan who supports the Norwood-Dingell bill and our great friend, the gentleman from Georgia (Mr. NORWOOD). We appreciate how he has pushed this issue, pushed the issue of patient protections in health care, accountability in managed care. In my opinion, every option on the floor today has the fixes to these problems, in one way or another.

In my view, part of that accountability must include having one's day in court, if one happens to be an employee who has been wronged. Three of the options we have considered today have that as a possible option, but we cannot let a legislative vehicle which fixes these problems also be used to create unlimited lawsuits, even against employers that had nothing to do with the health care decision.

Our substitute leaves Norwood-Dingell's patient protections intact, but closes the loopholes in the liability section.

This is the size of the Norwood-Dingell bill, a pretty thick bill. This is the size of the changes that we make to Norwood-Dingell. There are very few changes that we make. We just consider those closing those loopholes to the base business that might be an innocent bystander in this situation.

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Everybody here that I know of is interested in the same thing, trying to get more patient protections into the law of the land, but we just believe in different solutions to the problem. Vote for our substitute.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from Michigan for yielding me this time.

Mr. Chairman, I have been rather interested about the attacks on discretionary authority. Of course, I am not a lawyer, but I took a minute, and I tried to look up what in the world are they hanging their hat on. I mean, all discretionary authority really means is that an employer can make an independent decision. He has the power to do that about a health care plan.

What we do in this bill with the discretionary authority, we say that it is about a claim for benefits covered under the plan. That is what they have the authority to do. We are saying, ''do not use your authority to go in and deny care under this claim if it is a benefit in your claim, and you have to answer to that if you kill somebody.'' It is pretty simple.

I say to the gentleman from South Carolina (Mr. GRAHAM) I am all for limiting liability. Now, he knows that. That is why we have limited liability in our bill once one gets passed external review. I thought that it would make good sense. There is great limitation of liability at the State level. We see about half the States have really good punitive. Half the States, and sometimes not the same ones, have very good limitations on noneconomic. I think I am for limiting liability.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Texas (Ms. JACKSON-LEE).

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

Ms. JACKSON-LEE of Texas. Mr. Chairman, let me thank the distinguished gentleman from Michigan for this time and his patience and his leadership on this legislation, along with the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Arkansas (Mr. BERRY).

This has not come about overnight, and I think it is important to emphasize that because I have the greatest respect for the gentleman from New York (Mr. HOUGHTON). We have worked together. We understand the value of bipartisanship.

But on the floor of the House today, I have heard doctors maligned, I have heard unions maligned, I have heard lawyers maligned. I thought it would be best if someone got up and spoke about the American people, spoke about the young man that is joining us, children, or little Steve Olson that I spoke about yesterday, the little 3-year-old who needed a brain scan and was denied that by his HMO; or 11-year-old Paige Lancaster who for a long time had headaches, and her brain tumor grew for 4 years because her HMO denied her the service; or maybe Phyllis Cannon, a woman who died because of a lack of the ability to get the service she needed because of the HMO.

Although the intentions are good for this amendment, I believe that we will respond to the American people, and we will not malign them if we pass straight up the Norwood-Dingell bill that allows the patient-physician relationship to be the relationship that so many physicians who our Members of Congress have spoken about, the singular relationship of trust and respect and knowledge, so that that patient will have the ability to get the care that they need.

My good friend who is on the Committee on the Judiciary knows what this amendment does. This is the back door of tort reform. This gives one a single Federal action, and it closes the door to those citizens located in Oklahoma, in Texas, and Georgia who can go to their State courts. It is the same thing as the reform on the class action.

Mr. Chairman, the only bill that will respond to the American people is the Norwood-Dingell act. Save our children. Pass the Norwood-Dingell health reform package.

Mr. Chairman, today I rise to voice my strong opposition to the three substitute amendments to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act. H.R. 2723 amends current law to establish new patient protections, set nationwide standards for health insurance, and expand medical liability. The measure establishes basic standards for utilization review (i.e., establishing guidelines for how a plan reviews the medical decisions of its practitioner). In instances where the insurer and practitioner disagree about a patient's treatment, the insurer must disclose the reason for the negative coverage decision and inform the patient of his right to appeal. The bill establishes basic standards for the internal appeal process. If the internal appeal upholds the coverage denial, the patient may request an external review. The bill allows any decision involving a medical judgment to be appealed; however, if a benefit is specifically excluded from a health plan contract, it may not be appealed.

The measure expands health plan tort liability by permitting state causes of action under the 1974 Employment Retirement Income Security Act (ERISA; P.L. 93–406) to recover damages resulting from personal injury or for wrongful death for any action ''in connection with the provision of insurance, administrative services, or medical services'' by a group health plan. The bill prohibits insurers from retaliating against a patient or provider based on that individual's use of the review or appeals process and establishes other whistleblower protections.

The bill also includes a number of provisions designed to protect patients' rights and ensure access to health care. Specifically, the measure: Lifts so-called ''gag rules'' to allow free and open communications between patients and doctors in order for the patient to make fully-informed decisions about the best course of treatment; requires insurers to provide coverage, without prior authorization, for emergency care if a ''prudent layperson'' would consider the situation an emergency (resulting in serious injury or death); requires health plans and insurers to allows patients to choose their own primary care professional from the plan or insurer's network; requires HMOs to provide direct access to a participating physician that specializes in obstetrics and gynecology (OB–GYN) and allows parents to designate a pediatrician as a child's primary care provider; allows patients who have an ongoing special condition to have continued access to their treating specialist for up to 90 days in cases where the provider is terminated from the plan or if the plan is terminated; requires HMOs to provide a referral to a specialist for patients with conditions that require ongoing treatment; and requires health plans to disclose information to that patients are able to learn what their plan specifically covers, including benefits, doctors, and facilities, in addition to information on premiums and claims procedures.

In my home state of Texas, we already have effective laws that addresses this concern. The Health Care Liability Act, codified as Tex, Civ. Prac. & Rem. Code Ann. §§ 88.001–88.003 (West 1998) allows an individual to sue a health insurance maintenance organization, or other managed care entity for damages proximately caused by the entity's failure to exercise ordinary care when making a health care treatment decision.

In upholding portions of this forward thinking law that allows injured patients to bring suits for damages against health insurers for substandard quality medical care, District Judge Vanessa Gilmore wrote, ''[I]n light of the fundamental changes that have taken place in the health delivery system, it may be that the Supreme Court has gone as far as it can go in addressing this area and it should be for Congress to further define what rights a patient has when he or she has been negatively affected by an HMOs decision to deny medical care . . . .

''If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that ensures every patient has access to that care.'' Corporate Health Insurance v. The Texas Dept. of Insurance, 12 F. Supp. 2d, 597 (S. Tx. 1998). I could not agree more.

The three amendments made in order, appropriately called poison pills, would kill the bipartisan crafted Norwood-Dingell Bill. The first amendment, the Boehner bill would allow no new lawsuits, while the Norwood-Dingell measure would provide patients relatively open ability to sue in state courts. This is not acceptable. A patient's right to sue to address the denial of care by HMO is at the heart of Norwood-Dingell.

The second amendment, the Coburn-Shadegg amendment, is a wolf in sheep's clothing. It permits patients the right to sue. Should we applaud? I think not. Upon careful reading one finds that patients, under the Coburn-Shadegg amendment, can sue in either state or federal court, but not both, and would limit non-economic damages to $500,000.

The Graham-Houghton measure does not attempt to hide its attack on a patient's right to sue. It would limit damages in most cases to $250,000 and limit suits to federal court. This is outrageous. Think of the economic hardship that a family would endure if they have a loved one who is permanently and catastrophically disabled as a result of an HMO's negligence. To cap damages to $250,000 at a time when health care costs continue to rise smacks of callous indifference on the part of the sponsors of this measure.

These amendments would deny patients legal redress when he or she has been negatively affected by an HMOs decision to deny medical care. The first lawsuit to cite Texas' pioneering HMO liability law, filed against NYLCare of Texas, shows why the measure needed to be passed, according to physicians. HMOs here and around the country have argued that they shouldn't be liable for medical malpractice because they only determine insurance coverage and don't make medical care decisions. But the Texas suit, filed in district court in Fort Worth on Oct. 19, charges that a decision by NYLCare's reviewers to end hospital coverage for a suicidal patient led to his death. Despite his psychiatrist's objections, the patient did not protest the HMO's decision to release him from the hospital, and, shortly after discharge, he killed himself. ''HMOs may say otherwise, but they are quite clearly practicing medicine,'' said Robert G. Denney, MD, a Fort Worth psychiatrists familiar with the case. The lawsuit could spark interest in many state legislatures and Congress, where legislation similar to Texas' HMO liability law failed this year but is expected to be reintroduced.

Only Texas and Missouri have passed such laws, and Missouri officials reported that no suits have been filed yet under their 1997 law. Meanwhile, psychiatrists said a victory in Texas could help reverse massive cuts in mental health services in the past decade, as employers and managed care companies imposed tight coverage limits. ''HMOs and behavioral health companies are really going to take notice of this case because it's going to change how they manage their care,'' Dr. Denney predicted. At the time of filing, defendants in the lawsuit wouldn't comment on the case. In addition to NYLCare, which was acquired in July by Aetna U.S. Healthcare, the suit names Merit Behavioral Care Corp., which allegedly made the coverage decision as a subcontractor for NYLCare. Merit was acquired in February by Magellan Health Services, now the nation's largest behavioral health care provider.

Look at the Fort Worth patient, 68-year-old Joseph W. Plocica, who became suicidal after he was diagnosed with prostate cancer and lost his job of 11 years. Plocica was admitted to a mental health facility in late June by psychiatrist Harold Eudaly Jr., MD. About a week later, according to the lawsuit filed, Gary K. Neller, DO, a psychiatrist working for Merit in Dallas, told Dr. Eudaly by telephone that Plocica had ''used up his [hospital] days,'' even though the HMO's limit had not been reached.

Upon discharge, Plocica went home, drank a half gallon of antifreeze that night and died of the effects eight days later. ''This case appears to be very strong and raises some serious questions about promises made by the HMO,'' said Donald P. Wilcox, general counsel of the Texas Medical Association. In a TV ad for NYLCare 65, the Medicare product that Plocica enrolled in, the HMO asserts that, ''Some health insurance companies limit hospital days. NYLCare 65 will give you as many hospital days as your doctor will authorize,'' according to a transcript filed with the lawsuit. Wilcox added that since Plocica was covered by Medicare, the case will not be affected by the Employee Retirement Income Security Act of 1974, which shields self-insured companies from state actions.

It's no surprise that the first lawsuit under the Texas liability law involves mental health services, because ''the managed care industry has been arbitrarily cutting benefits,'' said Jefferson Nelson, MD, president of the Texas Society of Psychiatric Physicians. Nationwide, spending for behavioral health care benefits in the past 10 years has fallen by 54%, to $69.61 per person, compared with a 7.4% drop for general health care benefits, according to a 1997 study by the Hay Group for the National Association of Psychiatric Health Systems.

Although some states have passed mental health parity laws requiring coverage at the same levels as other care, the Hay Group found that by 1997, more than half of health plans had imposed limits on mental health hospital stays, typically 30 days. Coverage decisions are not typically made by behavioral care companies under contract to HMOs. Their reviewers ''constantly second-guess complicated cases that take a great deal of clinical judgment,'' said Houston psychiatrist Bernard Gerber, MD. When the HMO stops hospital coverage, patients often refuse to pick up the bill because they lack the funds to pay for the hospital stay and often want to be released, as in Plocica's case, Dr. Denney added. Such cases are ''frightening for psychiatrists because the liability rests with them,'' said Joanne Ritvo, MD, a Colorado psychiatrist and chair of the managed care committee at the American Psychiatric Association. The Texas lawsuit ''is one of the first cases to expose what is under the rock'' in managed mental health care.

Critics of the Texas law predicted an avalanche of HMO suits. With only one lawsuit filed under the Texas law, which went into effect in September 1997, there is hardly the avalanche of claims that some HMOs predicted when the measure was being debated, said Fort Worth attorney George Parker Young, who represents the Plocica family in the suit.

In other states where no such laws are on the books, there is little legal redress for patients suffering from negligent medical or reckless decisions made by their health insurance plans. Take for instance, Steven Olson—a once healthy, thriving two-year old child. After falling on a stick while hiking with his parents, two-year old Steven was rushed to the emergency room where he was treated. His mother returned him a week later because he was in great pain. He was treated for meningitis and sent home. Steven continued to complain about pain, but despite his parents' protests, the HMO doctors refused to perform a brain scan, even though it was a covered benefit. Steven eventually fell into a como due to a brain abscess that herniated. He now has cerebral palsy. An $800 brain scan would have prevented this tragedy.

In an even more tragic case, a woman attempted to switch doctors when it became clear that her original doctor would not fully examine a growing and discolored mole on her ankle. Paperwork and bureaucracy resulted in a six-month wait. Once the women finally visited a second doctor, she was immediately sent to a dermatologist who determined that the mole was a malignant melanoma. The woman died one year later.

Mr. Chairman, under the current federal law, many patients whose lives have been devastated or destroyed by negligent or reckless decisions made by their health insurance plans cannot go to court to obtain appropriate remedies under state law. The federal law—the 1974 Employee Retirement Income Security Act (ERISA)—was originally intended to protect the interests of employees covered by pension and health benefit plans offered by their private-sector employers. But the law is not being used as a shield against state tort liability by HMOs and other health insurers who claim that ERISA preempts state lawsuits against health insurers who cover private sector employees. Based on rulings of some courts, participants in ERISA-covered employee health plans are deprived of the protections afforded by the state common law of negligence and medical malpractice and state wrongful death statutes.

Although the courts do not all agree, many patients injured or killed by negligent or even deliberately reckless decisions of their HMO or other ERISA-covered health insurers have been unable to sue their health plan for damages. Injured patients and their families are limited to a narrow federal remedy under ERISA, which covers only the cost of the procedure that the plan failed to pay for, but does not include compensation for injuries or death

resulting from the denial of a medical treatment.

Mr. Chairman, this year, it should be a top priority of Congress to remove the ERISA preemption. Legal accountability for health insurance plans that make life-and-death decisions about medical care must be a part of any ''Patients' Rights'' bill that passes the Congress. Requiring plans to be legally accountable forces them to suffer consequences when they deny care on the basis of cost and harm results. If health plans are not accountable to patients for their decisions when harm results, they have no financial incentive to make appropriate medical decisions in the first instance.

Mr. Chairman, this is a historic time to stand up for the rights of patients. I ask my Colleagues to join with me in rejecting these poison pill amendments. I urge my Colleagues to support the bipartisan Norwood-Dingell measure which would take away the ERISA shield health insurers currently hide behind.

Mr. HOUGHTON. Mr. Chairman, I yield 3 minutes to the gentleman from Nevada (Mr. GIBBONS).

Mr. GIBBONS. Mr. Chairman, I thank the gentleman from New York for his willingness to share a little bit of his time for us folks.

What we are trying to do today is simply avoid a catch-22 provision which we are all knowingly pushing this country toward. Truly, if one looks at the Houghton amendment, it is the most balanced approach to the whole question we have got here today. For those of us who talk about patient reform, needed patient reforms, and HMO reforms, let me say that I agree with my colleagues. That is why I and all the colleagues who have joined on in this amendment are cosponsors of H.R. 2723, and we preserve those patient reforms. We do not change them at all.

But let me say that the 1.2 million constituents that I have in the Second Congressional District of Nevada sent me here to make this bill a little better. They sent me here to try to make the Norwood-Dingell better by adopting this substitute.

We have heard a lot of claims go about today about, yes, we are closing the door to States' lawsuits, that people will not have the chance, if they are in California, Texas, or Georgia, or whatever, to address those legal remedies that they have. Well, what about the other 44 States who do not have those same provisions?

By passing this bill without a uniform common approach to this law, we have shut the door to the citizens of those other 44 States. We are denying them the access to have and to seek damage and remedies that maybe some of these States do not have that we grant, that we allow, that we give this uniform approach under this bill here today.

Let me tell my colleagues a little bit about why we need to control the cost in this. If we look at the overall rise in health care, and I am sure the gentleman from Georgia (Mr. NORWOOD) knows about the rise in health care premiums, and I think it looks like double digit and has been double digits for a number of years.

In fact, in Nevada we just took a survey, and 12 percent of the employers, in the last year, said they have dropped their health care coverage for employees because of the continual rise in premiums. That survey also showed that 49 percent of those employers would also drop their health care coverage if these premiums continued to rise.

What we are trying to do here is to get to the issue of controlling the cost by giving them uniformity and certainty about damages that they have to estimate in their payment of premiums that continually rise, that put them out.

Let me say that for every 1 percent of premium increase, approximately 400,000 people around America go off of the insured roles on to the uninsured.

What we are doing here, Mr. Chairman, of course, is trying to give certainty to our employers that they know what their exposure to liability is. We all know that punitive damages cannot be insured, that this comes out of pocket of the employer. That is why we take punitive damages off the table. That is why we give a uniform approach to liability, to the remedies that are here. That is very important in this bill.

I would encourage all of my colleagues to support this amendment because I think it gives uniformity to a much needed piece of legislation.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Chairman, I thank the distinguished gentleman from Michigan (Mr. DINGELL), the ranking member, who is the senior Member of this House, for yielding me this time.

His father introduced health care legislation long before I knew anything about what Congress was doing. He has followed in that distinguished tradition.

I congratulate the gentleman from Georgia (Mr. NORWOOD) for his courage, his commitment, his focus to ensuring that patients and families and doctors had the opportunity to provide the medical care that the patients needed.

I rise in opposition to this amendment offered by one of the most distinguished and conscientious and honest Members of this House, the gentleman from New York (Mr. HOUGHTON) and the gentleman from South Carolina (Mr. GRAHAM).

I say to the gentleman, with all due respect, that we stand on the edge of an opportunity to pass historic legislation. This amendment will undermine that, not because this amendment, per se, is inherently bad, but because this amendment raises very complicated issues that, frankly, could have been raised in another way and could have been considered, in my opinion, much more straightforwardly and honestly as an amendment to the bill as opposed to a substitute to the bill.

I am reminded somewhat of what we did on campaign finance reform, not what the gentleman is doing, but the procedure that is being followed.

I urge my colleagues who have come this far to ensure that we complete this historic effort with the Norwood-Dingell bill and reject this amendment.

Vote overwhelmingly to pass this legislation. Let it go to conference where it will be worked on by, not only the Senate and the House, but by the President as well.

We will have an opportunity this year to do something that the American public will say is the best thing that we have done this year in ensuring that patients and doctors have the right and the opportunity to provide health care that the patients and doctors believe is necessary, not some third party. Defeat this substitute.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Chairman, first, I would like to salute all the Members that have worked so hard to bring forward the Dingell-Norwood bill. I would like to say some things today that really will remind us of some of the greatest things that have happened in this Chamber in the past chapters of American history: when a Congress and a President put together Social Security, when a Congress and a President put together Medicare.

In our day and our time, we, too, can do something noble. The American people are really pleading with us. They are saying to us in our town hall meetings, wherever we gather in our congressional districts all over the country, fix the ills in this system. There are parts of it that are broken. We need access. We need fairness. We want our physicians, our doctors, that sacred relationship between a patient and a doctor. We want the doctor to make the calls.

There is interference in the system, and we know what we need to do. The Patients' Bill of Rights is the bill that the American people genuinely support. We know that.

There is politics of special interests here that take amendments and debates one way or another. But I am convinced that the American people still respect access to the courts, not overuse of the courts, but access to the courts, and that they want the laws to be enforceable ultimately if that is where it has to go.

We can cast a vote that is going to keep faith with the American people. I believe that when they come back to judge us, that this will be the yardstick by which they will measure Members of the 106th Congress.

I ask my colleagues to defeat the substitute. There is no substitute for the Norwood-Dingell bill. Let us pass the Patients' Bill of Rights and do ourselves proud in this Congress.

Mr. HOUGHTON. Mr. Chairman, I yield 5 minutes to the gentlewoman from Missouri (Mrs. EMERSON).

Mrs. EMERSON. Mr. Chairman, before I even begin my formal remarks, let me say that the Houghton substitute incorporates all of the good in good work, the excellent benefits, the excellent changes in the health care delivery system that Norwood-Dingell has. It only changes the liability portion. Let me say that again. The entire Norwood-Dingell bill stays intact except for the liability provision. I just thought I ought to say that in response to the remarks of the gentlewoman from California (Ms. ESHOO).

Let me also say, Mr. Chairman, that, since I have been in Congress, I have had to intervene on behalf of many, many of my constituents, one of whom has been denied or was denied health care access when she had to have a hysterectomy. At least three doctors told her she had to have a hysterectomy.

This 43-year-old cafeteria worker from New Madrid was denied coverage and denied coverage and denied coverage. Her coverage said she can only have a uterectomy. She said, ''Well, if this is the only thing I can have, I will take this.'' But she had it, and she had pain and suffering, and she was even worse off after she had the uterectomy.

She went back to the three doctors, two of whom by the way were part of her health plan, one of whom was an outside doctor. All three doctors said once again, if she did not have a hysterectomy immediately, this woman is going to die. But the plan argued, ''No, she had a uterectomy. She does not need further surgery,'' even though it was obvious she was still suffering and was in great pain.

□ 1530

And only after I intervened and I threatened the plan with exposure to the news media did they finally relent and say, okay, go ahead. Well, my colleagues all know that that should not happen. Plans should not be threatened by Members of Congress in order to provide needed services to our constituents. But this has happened on many occasions. And for all the good health plans out there, there are some bad ones.

And let me say, as a former lobbyist for a small business and also as a former lobbyist for the insurance industry, that plans should be held liable in a court of law for acting irresponsibly and providing health care to consumers. I say that. But it should be responsible liability.

And let me say that after talking with employers in my district as well as a very, very close personal friend of mine who was both a trial attorney and a Taft Hartley Trust Fund attorney that I think the liability language in Norwood-Dingell does not protect labor unions or employers who provide quality health care coverage for their employees.

Let me give my colleagues an example. Let us say Joe Smith is denied coverage by his HMO. He is in a life-threatening situation and his doctor recommends experimental surgery; and because the HMO does not cover experimental medical practices, his coverage is denied. Now, the employer at this time inserts himself in the process because Joe is a long-time employee, his life is threatened; and, quite frankly, he wants to give Joe help. So the HMO grants Joe coverage because the employer has said I want Joe covered.

Now, another situation comes up with a different employee where the employer says, I am going to stay out of this and let the HMO do its job. So that coverage is denied. However, in this case the employer is liable because he acted out of compassion in the very first case.

This same thing happens on a daily basis with Taft Hartley Trustees each and every day. They grant coverage, where maybe they should not have granted coverage, but they did it out of compassion, and under Norwood-Dingell they would expose themselves to liability because of this compassion.

Now, Mr. Chairman, I have a couple of questions I would like to address to the gentleman from New York (Mr. HOUGHTON), if I might. It is my understanding that the Houghton substitute has added language now to section 302 of the liability provisions that make sure that companies and unions who do intervene on behalf of their employees are not held liable.

Mr. HOUGHTON. Mr. Chairman, will the gentlewoman yield?

Mrs. EMERSON. I yield to the gentleman from New York.

Mr. HOUGHTON. I would say to the gentlewoman, Mr. Chairman, that she is correct, we have added language that ensures that employers and unions who intervene on behalf of a patient in one circumstance are not held liable for actions committed and decisions made directly by the plan. Furthermore, employers and unions are not held liable for not intervening on behalf of their patients.

Mr. EMERSON. So, then, it is also my understanding that one of the key differences between Norwood-Dingell and the Houghton substitute is that Houghton clarifies that employers and unions cannot be held liable if they did not make the decision to deny medical care.

Mr. HOUGHTON. That is right.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from Washington (Mr. INSLEE).

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

Mr. INSLEE. Mr. Chairman, we should reject this amendment and pass the underlying bill. We should do it because America knows one thing in this debate with certainty. The amendment would divide this chamber. The Norwood-Dingell bipartisan would unite it.

This is a bipartisan bill, intended to unite us across the aisle. And the one thing we should know for sure, bills that unite us are superior to those that divide us. And if we think about why we are here, it is Congress, and Congress, by its meaning, is coming together. That is an American value.

If we look at the five values, and I encourage my colleagues to do this some day, carved on the bar of the House, there are five values: peace, justice, liberty, tolerance, and union. Let us vote for union today, union to do something meaningful for patients. It is what America wants.

Mr. DINGELL. Mr. Chairman, I yield myself 30 seconds for a colloquy with the distinguished gentleman from Georgia.

Mr. Chairman, I would like to engage my colleague to clarify the scope of the bill. I would say to my colleague that it is my understanding that our objective today here is to improve the delivery of health services, including medical, dental, and vision benefits for millions of Americans.

I also understand there is no intention for the provisions of this bill, including the claims provision of section 301, to govern other lines of insurance, such as disability income insurance or long-term insurance. Is that correct?

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. DINGELL. I yield to the gentleman from Georgia.

Mr. NORWOOD. The gentleman's understanding is exactly correct, Mr. Chairman.

Mr. DINGELL. Reclaiming my time, Mr. Chairman, I fully agree with my good friend.

Mr. Chairman, I yield 1 minute to the gentlewoman from Ohio (Mrs. JONES).

(Mrs. JONES of Ohio asked and was given permission to revise and extend her remarks.)

Mrs. JONES of Ohio. Mr. Chairman, I keep hearing the only difference between Houghton and the Norwood-Dingell amendment is that it only changes the liability. It only changes the liability. When a lawsuit is brought, the only thing that matters is liability. No liability, no lawsuit, no damages. Why penalize the American public by restricting their ability to seek damages?

The other thing that does not seem to want to be discussed on this floor today is the issue that someone who may be a victim of a violation of a claim or denial of a claim may be suing the doctor, may be suing the hospital, and the plan. The lawsuit against the doctor is in State court, the lawsuit against the hospital is in State court, the lawsuit against the plan should be in State court. Why require American citizens to go into Federal Court on the plan and the State court on the doctor and State court on the hospital?

Again, it only changes the liability. That is it, everybody. Liability. Keep it in State court. Support Norwood-Dingell.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentlewoman from California (Ms. WOOLSEY).

(Ms. WOOLSEY asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Mr. Chairman, after fighting for almost 2 years, this House is finally poised to pass meaningful managed care reform. The American people want us to do this, and I am delighted that this House is rising to the occasion. We are almost there.

We have been hearing some stories, though, about how HMO reform will make the sky fall. I want my colleagues to know that in my State of California our governor, Governor Gray Davis, recently signed landmark legislation that will provide HMO participants with major consumer protections and give health decisions back to 20 million patients and their doctors.

Now Californians have HMO accountability. Now Californians have a fair, timely, external grievance process. It should be an eye opener for all of us here today, because California, a large and diverse State, in fact with the population and the economy of a country, has patients first when they think of health care.

Mr. HOUGHTON. Mr. Chairman, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, where common ground exists, let me explain it. We are on the verge of doing something positive, but we are about to blow it. This bill, according to CBO, costs $7 billion to the Treasury. We have to work somehow to make that up.

Let me say this about liability and be as direct as I know how. 280 Members of this body have voted in the products liability area to limit damages, even economic damages, and change every law in every State and trump every court lawsuit anywhere in the country because they thought it was good for business and fair to plaintiffs.

We have passed the Cox amendment that would limit damage recoveries if medical malpractice occurred because we want to lower the cost of medicine and still give people a fair day in court.

Let me say this to my friends on the other side. We have a nice young man here who has probably a sad, bad story to tell. I want to help to make sure these things never happen again by getting the health care that people need. I do not want to drive people out of ERISA coverage. ERISA is designed at the Federal level to encourage people to have retirement plans and health care plans.

What have we done in the past? If somebody gets hurt by a doctor, this body was willing to say nationally that a plaintiff could only get this much money for the good of medicine. If somebody was blown up by a product, and I have had those cases, and I can show my colleagues files that would make them sick to their stomach, emotional things happen in lawsuit situations. I can show my colleagues product liability cases, but this House was willing to say this is all a plaintiff gets for the good of the Nation.

My colleagues, we are going to blow it if we do not reform the liability measure to keep it so people have a fair day in court but we do not drive well-meaning people out of business. It costs $7 billion already. This is the one area we have shown in the past we were willing to limit recovery for the greater good.

And I do not want to discount the fact that health care needs to be improved, but I am a lawyer and I know what we are setting up with a 50-State lawsuit form. We are going to drive people out of business.

Mr. DINGELL. Mr. Chairman, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, we are coming to the end of a long debate. We are coming to the end of 5 years of work.

This bill, the Norwood-Dingell bill, is not about the gentleman from Georgia (Mr. NORWOOD), nor is it about the gentleman from Michigan (Mr. DINGELL), the gentleman from Iowa (Mr. GANSKE), the gentleman from New York (Mr. HOUGHTON), or the gentleman from South Carolina (Mr. GRAHAM). It is about the people out in the country.

I want to tell a story about this little boy right here who is tugging on his sister's sleeve before he received HMO care. One night his mother found that he had a temperature of 104, 105. He was really sick. She phoned her HMO. The HMO said she could take him to one hospital, but only one, and that if she went to another one they would not pay for it. His mom asked where it was. And the person said, I do not know; find a map.

Well, it was a long ways away. And halfway there, 30-some miles into the drive, with more than that to go, they were passing one emergency room after another, one pediatric care after another, and this little boy is sick. But his mom and dad, they are not doctors; they do not know how sick. Before he gets to that emergency room, he has a cardiac arrest. His mom is trying to keep him alive and his dad is driving him there, and they pull into the emergency room and his mom leaps out and says, save my baby, save my baby. And a nurse comes out and starts resuscitation and they save his life.

But they do not save all of this little boy. Because of that HMO's medical judgment and decision, making him go 70 some miles instead of to the nearest emergency room, he ends up with gangrene of both hands and both feet. And this is that little boy after his HMO care.

The Norwood-Dingell bill would have prevented that. We do not want lawsuits; we want to prevent this. This little boy has a big heart, and he is going to do just fine. And his mama and dad, who are here today, they are making a place for him and making sure that he gets the kind of care he needs. But this little boy, if he had a finger and we pricked it, it would bleed. He is not an anecdote.

□ 1545

We need to fix this problem so that these cases do not happen. This little boy has met a lot of my colleagues today, and I encourage others to meet him. His name is James Adams.

I will tell my colleagues what we need to defeat this last substitute. We need to get a big vote for the Norwood-Dingell bill, and we need to send it to the conference. And instead of calling it the Talent bill, I have a suggestion. Let us call this bill the James Adams bill. Vote for the Norwood-Dingell bill. Vote against the substitute.

Mr. HOUGHTON. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee (Mr. HILLEARY).

Mr. HILLEARY. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, I am sitting here, and I am very conflicted about the fact that this young man is here today. I think the reason I am conflicted is because I think it borders, but probably does not go over, but borders exploitation of his condition.

But in a way, on final analysis, I guess I am glad that our friend the gentleman from Iowa (Mr. GANSKE) brought this up and really focuses exactly on what this is about. And it is about this young man.

We only have so much money in this country to focus on health care, and we should focus every bit of it that we can on young men like this one sitting right here. The bill that is the base bill here, in my opinion, and I am an attorney who has never tried a case in my life, but I believe I could drive a Sherman tank through that discretionary authority in the base bill.

So much money is available and that is it to help this young man. Now, if we can get to that deep pocket, which is that base company that contracts with that HMO, a good portion of that money available for this young man is going to go out the door to trial lawyers, who I do not malign. But if we have a choice between that limited funding of where that money should go, it seems to me that money should not go to the trial lawyers, it ought to go to young men like this young man right here.

I urge a vote for the substitute.

Mr. HOUGHTON. Mr. Chairman, I yield 30 seconds to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Chairman, I can show my colleagues cases of people that have lost their lives, lost their limbs in product liability suits that were treated by a doctor who was drunk. This House has in the past limited damage recoveries not because they are mean but because they want to keep people in business and lower the cost of medicine.

This young man, under this bill, would have a full range of damages available to him to treat him in the future to make him as best he can be in terms of damages.

What my colleagues are doing is they are not helping him. They are taking

people with health care coverage and for no good reason letting 50 States with unlimited damages take his mom and dad out of the health care market for no good reason.

Mr. DINGELL. Mr. Chairman, I yield myself 3 minutes.

(MR. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Chairman, this has been a long and exciting debate. It has been, I think, one of the finest I have had the privilege of seeing. I want to pay tribute to all of my colleagues on whatever side of the issue they might have been. It has been a strong and vigorous debate, but it has not been one which has been bitter or acrimonious. It is a real credit to the sincerity of the Members on both sides of the issue and it reflects great credit on this institution.

Now, my dear colleagues, if we defeat the substitute, we will move to vote on final passage. If we send this legislation to the other body for a conference, its final success is not assured. But I can tell my colleagues we have done our job and have done it well. We will pursue and try to see to it that the conference is completed to give this House and this Congress and this people a piece of legislation in which they may be proud and in which they will know that we have again made the HMOs of this country responsive to the needs and wishes of the people.

Members of both parties are concerned that if we vote for this legislation, we will not observe the customary budget requirements. I offer my colleagues firm assurance that we will, in this process, observe the customary budget requirements.

I have a letter from the President here in my hand, which I will insert into the RECORD, saying that we will do so and that the legislation will be paid for and offer my promise that that also will be so and that I will do everything that I can to see that nothing comes out of conference which does not pay the cost of the legislation.

I do not want to say anything bad about any piece of legislation. I am sure they have all been offered sincerely. I want to pay a particular word of compliment to my good friend the gentleman from New York (Mr. HOUGHTON). He is a great gentleman, and he is a man which I much admire and respect.

I also want to say a word of thanks to my good friends the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) and to their fine staff and to that of ours who have worked so hard to bring us to where we are. There are many here who deserve great credit for what it is that we have accomplished today, and I want them to know that this legislation is something which is good.

Many members on both sides of the aisle worked to make this day happen. Along with Dr. NORWOOD and Dr. GANSKE, several other Republican members labored long and hard. And on the Democratic side, I'd be remiss if I didn't mention MARION BERRY and my other good friends in the Blue Dogs, the cochairs of the health care task force, FRANK PALLONE, EVA CLAYTON, and CHRIS JOHN, and, of course, SHERROD BROWN, the subcommittee ranking member, and the other tireless Commerce Committee Democrats. We were well served by very capable staff, including Bridgett Taylor, Amy Droskoski, and Karen Folk of the Commerce Committee Democratic staff, and numerous excellent staffers from the personal offices of all involved on both sides of the aisle.

The remarkable thing is that the House has moved to a point where we now have agreement on all things save the question of litigation. But we have an example of what litigation means in matters involving HMOs in Texas under similar proposals of law, and that is that in 2 years, 4 million people have been involved in five lawsuits.

The total cost of those programs is less than 13 cents a month per subscriber. That tells us the system works, not at excessive costs but in a fashion which affords rights which have been denied to HMO subscribers and to allow them to be heard and get redressed for grievances and to get the abuses and the concerns which confront them adjusted.

I urge my colleagues to vote against the amendment. I urge my colleagues to support the bill.

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN. The Chair must ask all Members to refrain from alluding to any guest who might be on the floor of the House.

Mr. HOUGHTON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to thank the gentleman from Michigan (Mr. DINGELL) for his courteousness, the dean of our House, a very distinguished man, a great and dear friend.

This is the final vote to keep Norwood-Dingell intact and yet save the caregivers. I understand that the American people are pleading for something like this, and we are also.

I wish, as my friend from Maryland has said, that this had been an amendment. But it just was not. It was in the form of a substitute. I have no control over that. But I can only talk from personal experience that the Norwood-Dingell bill means that the health care is now going to be provided at a very scary cost.

My colleagues have got to believe me. They may not agree with me. They may be able to tear some of my statements apart. But having lived through this process and taking a look at what is now available, the basic thrust of my argument is absolutely right, no question about it.

The problem is that these people who have had problems, such as the gentleman from Iowa (Mr. GANSKE) has indicated earlier, if they do not have any health care, they cannot be helped at all.

I worked for many, many years, more than I would like to recount, for a company that was one of the first five in the country to offer health care to its employees. And I never thought in terms of employers or employees. We were members of the same corporation. I really believe that these people felt that we treated them correctly.

But as I looked over that plan, and if I put on my other hat and I was now a businessman, I would have to change my thinking. I could not stand the liability provision hanging over my head. And I would do a couple of things.

One of them might be to just give individual grants to employees, but that would not be good. We would not have the pooling. Many people would not have the money when they needed it. But the problem that I would have in being exposed to the liabilities, no matter how you want to define them, is they would be so great I could not continue the present plan as it is.

Now, let me just say one other thing. We have heard from people who care very much about this. We have heard from lawyers. We have heard from doctors. I would like in pleading here, as others have, to plead for the employees and employers of corporations and the small companies who are going to be dramatically affected unless something can be done to refine this bill.

Mr. Chairman, I yield back the balance of my time.

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the distinguished gentleman from Texas (Mr. STENHOLM).

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

Mr. STENHOLM. Mr. Chairman, I rise in support of H.R. 2723.

Mr. Chairman, I rise in support of the Bipartisan Consensus Managed Care Act, offered by Representatives CHARLIE NORWOOD and JOHN DINGELL. While I do have some remaining concerns with some of the provisions in this legislation, I believe that Dr. NORWOOD and Mr. DINGELL have made a sincere effort to work with me and others to address the legitimate concerns with their bill. Whenever issues were brought to their attention, they took the time to consider these suggestions and worked to resolve them. I commend both the Members and their very capable staffs for their diligent efforts to develop bipartisan, meaningful managed care reform. I am pleased that they have been able to put together a bill which is much improved from the legislation considered by the House during the 105th Congress.

Our health care system poses a challenging area of public policy. I believe that is it important that we try to strike a balance between the rights of patients, the duties of physicians, the operations of insurance companies, and the ability of employers to provide health insurance for their employees. One of the most difficult issues to address throughout this debate has been the matter of liability. If a health plan's actions cause harm to a patient, the plan should be held accountable. I believe that the internal and external appeals processes included in this bill will enable patients to get the care that they need and therefore preclude

the need for litigation. In fact, this bill clarifies that a patient must go through an external appeals process before going to court unless they already have suffered an injury or death. Furthermore, this bill includes provisions which ensure that employers will not be subject to liability unless they specifically act as an insurer and decide that a specific enrollee shall not receive a certain benefit that is covered. I have long supported tort reform, and I certainly do not want to see an increase in litigation. I believe that the limited scope of this bill's liability provisions make lawsuits a last resort that is available only in egregious cases where all other avenues have been exhausted.

I believe that the managed care plans in my district, First Care, offered by Hendrick Health System, and HMO Blue, offered by Abilene Regional, are doing a good job. I hope that the Bipartisan Consensus Managed Care Act will highlight the work of these responsible plans. In fact, the bill contains a number of provisions that these managed care plans already are using to provide better care for their patients.

I am disappointed that the majority party did not allow the sponsors of this legislation the opportunity to pay for their bill. I believe that it is extremely important that we follow the budget rules that require us to pay for the legislation we pass. I continue to oppose any legislation that would use any of the budget surplus until we have an overall budget plan that protects Social Security and Medicare. I know that the authors of this bill agree with this position and offered a proposal to pay for the costs of the bill. The only reason that this bill is not paid for is because the majority leadership prevented the authors of the bill from doing so. I am voting for this bill today with the understanding and expectation that provisions paying for it will be added in conference. I am pleased to that the President has indicated he will not sign it unless its costs are fully offset by the conference committee.

Even if we pass this legislation to ensure patients have rights in their health care, there is still much work to be done. The rising cost of health care and the growing number of uninsured citizens in our nation are alarming. In addition to giving patients who already have access to health care the ability to have a say in their health care decisions, we also have an obligation to work to see that everyone has access to health insurance.

There are many valid and difficult issues to resolve as we seek to improve our health care system. H.R. 2723 isn't the final answer but it moves us in the right direction. I urge my colleagues to support the Norwood-Dingell bill.

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the distinguished gentleman from Illinois (Mr. COSTELLO).

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

Mr. COSTELLO. Mr. Chairman, I rise in opposition to the substitute and in strong support for the Norwood-Dingell bill.

Mr. Chairman, I rise today in strong opposition to the process imposed in the House today by the Republican leaders. Once again the Republican-led Congress has made in order a rule they know will defeat the bipartisan Norwood-Dingell bill, the only bill that could provide real managed care reform for 32 million Americans. This is the Republicans clever way of fooling the public into thinking they would like to pass a real managed care bill.

Mr. Chairman, the rule does not allow the bipartisan Norwood-Dingell bill to be offered in its original form and then links it with another poorly crafted bill that will deny access to the 32 million uninsured individuals in the lowest income bracket. This scheme is unacceptable, the Republican Leadership should be ashamed.

The ''access bill'' that will be tied to the real managed care bill is for the healthiest and wealthiest of individuals. By expanding Medical Savings Account (MSAs), the access bill discourages preventive care, and undermines the very purpose of insurance. When we voted on the Kennedy-Kassebaum Health Insurance Portability Protection Act in 1996 I supported the MSA demonstration project. However, this demonstration project turned out to be a failure. Of the 750,000 policies available only 50,000 have been sold. In my own Congressional District in Southwestern Illinois my constituents do not have access to these policies.

This access bill and the rule is just another attempt by the Republican-led Congress to undermine a bipartisan bill that could provide relief for millions of Americans. I am outraged that the Rules Committee denied Representative DINGELL's request to offer an amendment to pay for this legislation. As a general rule the Republican leadership demands that legislation not bust the budget caps imposed in 1997. While the Norwood-Dingell bill was not expected to require additional spending, the Congressional Budget Office estimated it would cost $7 billion. Representative DINGELL offered to offset the bill so that Members like myself who wish to protect Social Security could cast their vote in support of real managed care reform while ensuring the Social Security Trust Fund would not be touched.

As a cosponsor of the Bipartisan Consensus Managed Care Improvement Act—legislation strongly supported by doctors and by the American Medical Society and the Illinois State Medical Society—I believe it is the only real reform bill that will provide a comprehensive set of consumer rights that includes guaranteed access to emergency care and specialists, choice of providers, and strong enforcement provisions against health plans that put patient's lives in jeopardy. I am pleased the bill protects our small business owners by excluding businesses from liability if they do not make the decisions. This bill contains provisions that create safe harbors to ensure that no trial lawyer will accuse an employer of making a decision by simply choosing what benefits are in a plan or providing a patient benefit not in a plan. I am encouraged by the State of Texas who gave their citizens the right to sue HMO's for the past two years. In that time there have only been four cases filed.

I urge my colleagues to oppose this rule and support real managed care reform legislation. Vote for the bipartisan Norwood-Dingell legislation.

Mr. DINGELL. Mr. Chairman, I yield 3½ minutes to the gentleman from Georgia (Mr. NORWOOD) who has worked long and hard on this matter and shown extraordinary skill, ability, dedication, and energy. And those are characteristics I have seen in the gentleman from Iowa (Mr. GANSKE).

Mr. NORWOOD. Mr. Chairman, well, it is almost over. I think it has been a great 2 days, frankly. There are so many good ideas and so many good people in here, all of whom have brought the most interesting points of view to this debate. I am proud of this House. I agree with the gentleman from Michigan (Mr. DINGELL) that it has been a very civilized, correct type of debate.

Mr. Chairman, I have had the strangest feelings. This has been going on for me for a long time. I woke up today and I felt, well, it must be May 1969. The 101st Airborne Division was ready to take Hamburger Hill in a place far away in Vietnam. It had been their tenth try. They had to fight on bad ground. And they had to win.

That division one more time locked and loaded and went straight uphill to take Hamburger Hill, and that day they won for America.

I feel like we are running uphill our tenth time today, and we are going to get to the top of the mountain, and we are going to do it for America.

I have tried, interestingly enough, for 4 years to make this a partisan debate. I did everything I could do, I think, to try to get the Republicans to take this issue. This is such an important issue to America, so important to so many people. Each one of us, each member of our families, each one of our constituents, every American is what this issue really was all about.

I realized this year that we will not succeed that way, that for us to change the law in this country to protect our patients, we have to do it in a bipartisan fashion. That is the only thing that will work. That is the only thing that will really give us the new law that we need.

I am asking my colleagues today, do not vote for this because they are a Republican, do not vote for this because they are a Democrat. That is not what this is about. I want them to vote for this bill, I want every one of them to vote for this bill today as an American.

Let us show this country that on issues of this high quality and importance for the American people, we are going to come out of this House. And we are going to produce a good bill. We are going to conference, and we are going to face an uphill battle.

Everybody knows that. We are going to go to conference and listen to my friend the gentleman from New York (Mr. HOUGHTON) and the gentleman from South Carolina (Mr. GRAHAM) and the gentleman from Tennessee (Mr. HILLEARY) and others, and we are going to try to make it even better. And we can do that, and we can do that if we work together.

I mean, everything maybe does not have to be bipartisan, but today's vote is an American vote. I ask every one of my colleagues, if they possibly can, vote for this bill today. And if they cannot, I respect them. And their opinion is important. But if you can, do.

□ 1600

Mr. Chairman, I thank my colleague, an interesting hard-working gentleman, a man that will tell it straight, and, boy, do I admire that. I thank the gentleman from Iowa (Mr. GANSKE) for his hard work. I thank the gentleman from Oklahoma (Mr. COBURN). As my colleagues know, we are going to pass a bill out in an few minutes that the gentleman from Oklahoma wrote, or he certainly helped write. He will probably fuss about me saying that, maybe one or two things. But I thank the staffs in our offices, all of our offices that have worked so hard.

Everybody, cast that American vote.

The CHAIRMAN. The time of the gentleman from Georgia (Mr. NORWOOD) has expired.

Mr. HOUGHTON. Mr. Chairman, have I any time left?

The CHAIRMAN. The gentleman from New York has 1 minute remaining.

Mr. HOUGHTON. Mr. Chairman, if the gentleman from Georgia would like another minute, I will yield him the balance of my time.

The CHAIRMAN. The gentleman from Georgia is recognzied for 1 minute.

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from New York for yielding this time to me, but I will tell my colleagues I am sort of tired of hearing myself talk. It has all been said, and it has all been done, and what we need to do now is mount the top of Hamburger Hill.

Mrs. CHRISTENSEN. Mr. Chairman, and my colleagues, while the Houghton-Graham amendment is a bit more reasonable than the previous two, and I think is an attempt at promoting a compromise—I still must oppose it.

I will admit that as a physician, I may be biased on this issue. Why should I as a physician be liable to be sued for a decision that was made by an HMO plan I work for, but the plan only be subject to arbitration.

This will not bring the kind of accountability necessary to make sure that plans act in the best interest of the health of the patient, and not just on cost.

Once again I must restate, that a lot of work and compromise went into crafting the bipartisan Norwood-Dingell bill. No one got everything they wanted in the bill. In fact, I am particularly disappointed that my own managed care bill—to ensure access to managed care plans for residents and physicians living and working in medically underserved areas—was not included in the Dingell-Norwood bill.

However, in spite of this, I still say that it is the best managed care reform bill that we could get because it addresses, in a comprehensive way, the problems that the corporations will not address without legislation.

So while my friends, Mr. HOUGHTON and Mr. GRAHAM may mean well in offering their substitute, they don't go far enough.

The Norwood-Dingell bill is the only proposal that offers real managed care reform. Let us not amend it. Let us vote for the Norwood-Dingell-Ganske bill and against any and all amendments.

Mr. CLAY. Mr. Chairman, I rise in opposition to the Houghton amendment. This amendment is no different than the Coburn substitute. It makes it so difficult for an individual to bring a lawsuit that in effect there is no right to sue. Only if an individual can jump over the high hurdles that this substitute puts up, can anyone receive a modicum of redress.

Under Houghton, an individual has to prove three key points. First, that a person who had sole final authority exercised that sole final authority. Second, that that person failed to exercise ordinary care in making an incorrect determination. And third, that the denial was the proximate cause of the injury of death. In most health plans, it is unclear who has the final authority and individuals will be hard pressed to know and prove who was the person who actually denied their care.

Houghton furthermore, requires that the court give the plan's decision substantial weight. This means that there is a presumption that the plan was right. Individuals and courts will be hard pressed to override this presumption. Only in the most egregious cases will there ever be any relief.

Most of the other provisions in Houghton are similar to the Coburn substitute. Both of these substitutes make it so difficult to bring a suit that only a few individuals will ever be able to meet its tough standards. This isn't what the American people want. The American people want a reasonable way to hold health plans accountable. Americans deserve the same protection against health plans that they have when they buy a car or go to the supermarket. Oppose the Houghton substitute.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. HOUGHTON).

The question was taken; and the Chairman announced that the ayes appeared to have it.

RECORDED VOTE

Mr. DINGELL. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 160, noes 269, not voting 5, as follows:

[Roll No. 489]

AYES—160

Aderholt
Archer
Armey
Baker
Ballenger
Bartlett
Barton
Bateman
Bereuter
Bilirakis
Bliley
Blunt
Bono
Brady (TX)
Bryant
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth-Hage
Coble
Coburn
Collins
Combest
Cooksey
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Dickey
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fossella
Fowler
Gallegly
Gekas
Gibbons
Gillmor
Goode
Goodling
Goss
Graham
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hill (MT)
Hilleary
Hoekstra
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Kelly
Kingston
Kolbe
Kuykendall
Largent
Latham
LaTourette
Lazio
Lewis (CA)
Lewis (KY)
Linder
Lucas (KY)
Lucas (OK)
McCrery
McHugh
McInnis
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Myrick
Nethercutt
Northup
Nussle
Ose
Packard
Pease
Pickering
Pitts
Porter
Portman
Pryce (OH)
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ryun (KS)
Salmon
Sensenbrenner
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (TX)
Souder
Spence
Stearns
Stump
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOES—269

Abercrombie
Ackerman
Allen
Andrews
Bachus
Baird
Baldacci
Baldwin
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bass
Becerra
Bentsen
Berkley
Berman
Berry
Biggert
Bilbray
Bishop
Blagojevich
Blumenauer
Boehlert
Boehner
Bonilla
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Burr
Burton
Buyer
Campbell
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Cook
Costello
Cox
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Foley
Forbes
Ford
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Ganske
Gejdenson
Gephardt
Gilchrest
Gilman
Gonzalez
Goodlatte
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Herger
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hobson
Hoeffel
Holden
Holt
Hooley
Horn
Hostettler
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kasich
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kleczka
Klink
Knollenberg
Kucinich
LaFalce
LaHood
Lampson
Lantos
Larson
Leach
Lee
Levin
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manzullo
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntosh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Nadler
Napolitano
Neal
Ney
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickett
Pombo
Pomeroy
Price (NC)
Quinn
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Royce
Rush
Ryan (WI)
Sabo
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Saxton
Schaffer
Schakowsky
Scott
Serrano

Sessions	Sununu	Vento
Sherman	Tanner	Visclosky
Shows	Tauscher	Waters
Sisisky	Taylor (MS)	Watt (NC)
Skelton	Terry	Waxman
Slaughter	Thompson (CA)	Weiner
Smith (NJ)	Thompson (MS)	Wexler
Smith (WA)	Thurman	Weygand
Snyder	Tierney	Whitfield
Spratt	Toomey	Wise
Stabenow	Towns	Woolsey
Stark	Turner	Wu
Stenholm	Udall (CO)	Wynn
Strickland	Udall (NM)	
Stupak	Velazquez	

NOT VOTING—5

Fletcher	Kaptur	Traficant
Granger	Scarborough	

□ 1622

Mrs. MCCARTHY of New York and Messrs. BACHUS, MANZULLO, SANFORD, KASICH, CROWLEY and PETRI changed their vote from ''aye'' to ''no.''

Messrs. CRANE, CHABOT and ADERHOLT and Mrs. NORTHUP changed their vote from ''no'' to ''aye.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. FLETCHER. Mr. Chairman, on rollcall No. 489, I voted in the machine but it did not record my vote. I voted ''aye.''

Ms. ROYBAL-ALLARD. Mr. Chairman, I rise today in support of the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act of 1999 and in support of effective use of the National Practitioner Data Bank.

Unfortunately, the Republican leadership, in restricting the debate on managed care reform, has prevented many promising ideas from being discussed, including an amendment I submitted to the Rules Committee about the National Practitioner Data Bank. The purpose of my amendment was to encourage health care providers to use the existing National Practitioner Data Bank. This would allow health consumers to make accurate and informed decisions about their health care.

We've all read about these terrible stories where doctors, whose licenses have been suspended by one state, to relocate to another state and start their harmful medical practices all over.

The National Practitioner Data Bank was established as part of the Health Care Quality Improvement Act of 1986 to try to prevent this from happening.

The purpose of the data bank is simple: to help prevent incompetent doctors, dentists, or other practitioners from moving from one state to another without a state discovering their previous history of unethical or incompetent medical practice.

The data bank contains information on malpractice payments, licensure actions taken by state medical boards, professional review actions taken by hospitals or HMOs, actions taken by the Drug Enforcement Agency, and Medicare/Medicaid exclusions.

Information is made available only to registered entities such as state licensing boards, professional societies, HMOs, PPOs, and group practices.

Hospitals are required to query the NPDB when hiring medical staff and at least once every 2 years for those already on staff or having clinical privileges.

However, other health care entities may consult NPDB but are not required to.

My amendment would have encouraged the use of NPDB by health plans and HMOs in order to give consumers confidence that bad actors are not employed or covered by their health plan. The amendment simply stated, that in the ''Patient Access to Information'' section of the bill, along with a doctor's name and address and availability to new patients, an HMO or a health care plan must indicate whether the National Practitioner Data Bank has been consulted—essentially, whether a background check has been done on the doctors in their list. The amendment did not require HMOs or health plans to consult the data base.

The fact is, more and more Americans are now covered by HMOs.

Many have little choice in the matter—80% of small businesses and over 50% of large businesses offer one and only one health care plan to their employees.

In the past, most of us were able to choose a family doctor or a specialist because someone we knew or trusted—a relative, a family friend—recommended them to us.

Under most HMOs, we are handed a list of participating doctors and told these are the only doctors we can pick.

Yet we may have no idea who they are—it may be a list of complete strangers.

Are they licensed? Has their license been suspended in another state? Has another state taken a disciplinary action? Have they been sued for malpractice in the past? If so, was it an aberration or is it a regular occurrence?

It seems the very least we should expect is that our health care plan or HMO has run a background check on these doctors. These are legitimate questiions the health plan or HMO should know the answer to.

Practically speaking, I had hoped such disclosure would serve as an incentive for health plans and HMOs to check up on who they are hiring, or who they are including in their list of covered physicians. My amendment would not have done everything, but it would have represented a small step forward in the area of consumer access to information that will help us move ahead for a more open health care system with access to the information people need to make informed medical decisions.

I urge my colleagues to pass the Norwood-Dingell bill today to begin the long process of reforming our health care system, expanding coverage, and bringing quality health care to all our people. I hope that we can move quickly in the near future to discuss ways of making the National Practitioner Data Bank effective, and to consider related legislation to prevent medical malpractice and give consumers the confidence that unethical or illegal practitioners are not hiding out in the medical system, waiting to prey on their next unsuspecting patients.

Mr. CUMMINGS. Mr. Chairman, an historic American tale teaches us the traits necessary to follow the road to your dreams—a brain, a heart and courage. Today, we must use these traits to knock down the GOP Substitutes that are roadblocks placed on our path toward making the American people's dream of a meaningful patients' bill of rights a reality.

As lawmakers, we have a duty to use our brains and hearts, and to have the courage:

To knock down GOP roadblocks to expanded access to specialists who have the requisite expertise to treat patients;

To knock down GOP roadblocks to ensuring that individuals have access to emergency care, without prior authorization, if a ''prudent lay person'' deems it an emergency;

To knock down GOP roadblocks to increased access to prescription drugs through participation of plan physicians and pharmacists in the development of any drug formulary;

To knock down roadblocks to prohibiting gag rules that would allow patients to be informed of all of their treatment options; and

To knock down roadblocks to holding health plans accountable for decisions about patient treatment that result in injury or death.

To knock down roadblocks to allowing provisions, as requested by the Democratic leaders on the bill, in the bipartisan managed care legislation that would ensure that the Social Security Trust Fund is protected by including revenue offsets.

These GOP roadblocks have been placed to steer us down an alternate route filled with hidden, poisonous traps and leading to a dead end, with no real access for the 837,000 Marylanders and 44 million nationwide who are uninsured.

So, I urge my colleagues—use your brain, listen to your heart, and have the courage to pass the managed care reform the American people have mandated.

Knock Down the GOP substitutes and support the Norwood-Dingell bill.

Mr. CROWLEY. Mr. Chairman, I rise today in support of H.R. 2723, the Bi-partisan Consensus Managed Care Reform Improvement Act of 1999 and against any attempts to weaken its provisions. I also want to express my dismay at the political maneuvering by the Republican leadership to defeat this bipartisan legislation before it even came to the floor.

Mr. Chairman, the American public needs our help. All too often, a constituent will contact my office at the end of their rope. They, or someone in their close family, will have received a devastating medical diagnosis. They attempt treatment, only to have their insurance company deny coverage—coverage they are entitled to! Our constituents are facing a declining quality of care and have basic medical decisions being made not by qualified medical professionals, but by insurance plan administrators. As United States Representatives, we cannot allow this to continue.

Quality health care is a right, not a privilege. Those who have coverage by a Health Maintenance Organization deserve better than bureaucratic decisions. Additionally, access to health care is something that should be available to all Americans, not just those who can afford it. I am proud to be a cosponsor of the Norwood-Dingell bill which extends patient protections to the 161 million Americans who are covered by private health plans. Norwood-Dingell will make health plans accountable, offer more protections for women and children and prohibit gag rules. Overall, the Norwood-Dingell bill provides comprehensive reform which assures individuals of emergency services coverage; access to specialty care; chronic care referrals; ob/gyn services; continuity of care' access to clinical trials; access to prescription medications; internal and external appeals processes plus a utilization review; anti-gag and provider incentives; payment of health claims in a timely manner; paperwork simplification; and importantly, insurer liability—giving patients the right to sue over

insurance made treatment decisions that result in injury or death.

The three substitutes do not provide the comprehensive reforms contained in H.R. 2723. The Boehner substitute fails to cover all privately insured Americans. It leaves out millions in the individual market. Additionally, its external appeals process does not provide for an independent and timely appeal. The Boehner substitute does not provide for access to specialty care. It provides for clinical trials for cancer victims, but not for those suffering from other debilitating diseases, such as multiple sclerosis. And finally, the Boehner substitute does not allow patients to hold their plan accountable if it causes injury or death. It allows HMOs to remain immune from accountability for their actions.

The Coburn substitute grants sweeping judicial powers to private medical review bodies to determine harm and proximate cause, with no rights or due process requirements for the patient. The finding by the entity would not be subject to challenge or appeal, but would become legally binding in all judicial venues. Additionally, the Coburn substitute purports to add an untested federal remedy to the current range of judicial remedies under both ERISA and state law for cases involving patient injury. But the substitute would effectively give managed care companies a complete shield against any further medical malpractice cases under state law. Finally, the Coburn substitute only permits actions against individuals who have the authority to make the final determination of coverage. This provision could shield from liability a utilization review company under subcontract to the HMO, thereby undercutting any incentive to ensure better utilization review procedures.

Lastly, here is the Houghton substitute, which is basically Coburn-Shadegg revisited. It would strike the Norwood-Dingell state court accountability and put in its place a very limited and untested federal cause of action. The Houghton substitute does not allow for punitive damages at all, even compensatory damages are unavailable if the external review agrees with the HMO. The Houghton substitute in effect creates yet another system for hearing these claims by also allowing for binding arbitration.

Mr. Chairman, the only true Patient's Bill of Rights is contained in the Norwood-Dingell Bi-Partisan Consensus Managed Care Improvement Act. I urge all my colleagues to put aside the partisanship and the political maneuvering and institute reforms that will help the majority of Americans.

Mr. LEVIN. Mr. Chairman, I rise in strong support of the Dingell-Norwood ''Patients' Bill of Rights'' legislation.

Well, here we are again. More than a year has passed since the last time the House debated HMO reform. Last year the decision before the House was between the half-hearted, watered-down approach offered by the House Leadership and a strong, enforceable patients' bill of rights that would empower patients and allow health care professionals to perform their jobs without interference from the health insurance bureaucracy.

The choice before the House is the same today. We can vote for real HMO reform by voting for the Dingell/Norwood bill or we can vote for something much less. Medical decisions should be made by doctors and patients, not by insurance companies. In addition, HMO's must be held accountable when their decisions cause a patient's injury or death. A right without an enforceable remedy is no right at all.

The story of one of my constituents, Timothy, painfully illustrates the importance that this House pass the right reform package. After an accident at work, Timothy developed a rare nerve disorder, Reflex Sympathetic Dystrophy. People with this disease experience extreme pain when their skin is blown or even touched. If the condition is diagnosed and treated within the first few weeks, the patient can usually expect great relief and often complete remission of the disease.

Reflex Sympathetic Dystrophy is treated with special injections given by an anesthesiologist. Both Timothy's primary care physician and orthopedist agreed that this treatment was needed.

When Timothy went for treatment he was told his managed care plan would not cover the injections. He was told that the HMO was not confident that his condition warranted treatment and an appointment would be made to get a second opinion.

The appointment did not occur for 3 months! By that time it was too late for treatment. Timothy was in constant agony. Some months later, Timothy had a massive heart attack and died. His cardiologist found no sign of heart disease, and suspected that the heart attack was directly related to the stress and pain caused by his condition—a condition that may have been cured with prompt medical treatment.

Today we have a chance to do what the Congress failed to do last year and give the American people a strong, enforceable Patients' Bill of Rights. Vote for real reform and support Dingell/Norwood.

Mr. EVANS. Mr. Chairman, I rise to express my strong support for H.R. 2723, the Bipartisan Managed Care Improvement Act of 1999.

Today, Democrats and Republicans have joined together to advocate for reforms that will restore control over medical decisions to patients and doctors and make the health care system more responsive for all Americans.

The Bipartisan Managed Care Improvement Act institutes meaningful, common sense reforms of managed care. It will ensure that people may seek care in emergencies without having to wait for prior authorization from an insurer. It will guarantee that patients who need specialized care will have access to appropriate specialists. It will improve the quality of care for women and children, allowing women to see obstetrician/gynecologists without referral and ensuring that children can see pediatricians as their primary care physicians and pediatric specialists if necessary.

This bill establishes real accountability for health insurance companies when they make medical decisions, accountability that has been lacking under ERISA. With a strong, two-stage process of internal and external appeals for denial of care, patients will now have recourse to challenge decisions and have their cases resolved by an independent board of health professionals. And in those extreme cases when a patient suffers injury or death due to denial of care by a health plan, patients and their families will have the same access to state courts for damages that is currently available to all patients whose plans are not covered by ERISA.

I am also proud that H.R. 2723 will help people in the most dire of situations receive coverage for routine care during clinical trials. This issue was brought to light for me by a constituent, LaDonna Backmeyer, who is bravely fighting a rare form of cancer, renal leiomyosarcoma. LaDonna has participated in a clinical trial at a National Cancer Institute-designated Comprehensive Cancer Center, and under the bill, the costs of routine care during a clinical trial would be covered. I want to thank LaDonna for educating me, for inspiring all of us with her courage, and for being willing to speak out for the need for reform of our health care system.

At its core, this bill is about giving back control over medical decisions to real people and their doctors, and restoring faith in the American health care system as the best in the world. I urge my colleagues to vote for H.R. 2723 and to enact these critical reforms.

Mr. COYNE. Mr. Chairman, it is time for Congress to act on the Bipartisan Managed Care Improvement Act. American families have already waited far too long for us to pass these common-sense consumer protections.

Over half of American workers are not given a choice of health insurance plans by their employer. Under current law, many of those workers and their families have no place to turn if they are harmed or killed by their HMO's decisions.

The consumer protection bill we are currently debating would guarantee basic health rights for these workers. If this bill passes, families will know they can see specialists when they need to, appeal unfair denials, and seek emergency care when they experience severe pain. Doctors will be free to tell their patients all the options and to make medical decisions without fear of retribution from health plans. Health plans will be accountable if they make medical decisions, just as doctors are now.

Some would suggest that this bill undermines our long-held goal of health coverage for all Americans. They say that if we don't let HMOs reduce the quality of health care, health insurance will be too expensive for families to afford. They would have us believe that a health insurance plan that protects basic health care rights is out of reach for the average American. That is wrong. It is our responsibility to find a better way to help the uninsured than telling them to buy bad health coverage, coverage which may not be there when they need it.

I urge my colleagues to join me in supporting this important legislation. By enacting this legislation, we will make sure that health insurance coverage is worth having. Once we have done that, I hope we can work together on a bipartisan basis to extend that coverage to every American.

Mr. SANDLIN. Mr. Chairman, I rise in strong support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 introduced by Representatives Norwood and Dingell. This is the only bill that would enact consumer protections through responsible health care reform.

The Norwood-Dingell managed care bill provides Americans with many important patient protections such as access to needed health care specialists; access to emergency room services when and where the need arises; assurance that doctors and patients can openly discuss treatment options; an external, third-

party appeals process for service denials; access to personal medical information; legal redress for injury or death due to the denial of care covered under a managed care plan. I am a cosponsor of H.R. 2723 because it will provide comprehensive and enforceable protections that American's health care consumers demand and deserve.

By 1997, more than 80 percent of privately insured Americans were enrolled in managed care plans-up from just 13 percent in 1987. As we increase access to health care, we must not allow unqualified parties to make critical decisions about patient treatment. Patients needed to feel confident that their doctors are giving them all necessary information, without concern of retaliation by a health insurance provider.

Insurance bureaucrats want to tell patients they know medicine better than their doctors. Let's tell them they do not. The Norwood-Dingell bill would prohibit health plans fro silencing any health care professional from advising a patient about the patient's health status or available treatment, regardless of whether the plan covers such a treatment or care.

Americans also deserve access to emergency care services. Let me give an example of why this protection is so important. Jess Reed suffered a stroke at home. He was rushed to the closet hospital. The HMO insisted he be taken to another hospital, causing a 2–3 hour delay in treatment. Delay seriously exacerbated his condition and prevented full recovery from his stroke. The Norwood-Dingell bill would require health plans to cover the emergency care of a ''prudent layperson'' in any hospital emergency room, without prior authorization.

Another reason I support the Norwood-Dingell bill is to assure patients access to necessary prescription drugs. Prescription medications should not be one-sized-fits all. For plans that use a formulary, Norwood-Dingell provides that beneficiaries must be able to access medications that are not on the formulary when the prescribing physician dictates.

One of the most important distinctions in this debate is whether or not we truly hold health plans accountable. Opponents of real accountability argue that patients who have been unfairly denied health care should be limited to external appeals. But external reviews is simply not enough to protect patients against the worst managed care abuses. Accountability is the ultimate deterrent and is an essential last resort when all else fails. Only legal accountability gives injured patients what they need to ensure that managed care does the right thing and puts patients first. And only Norwood-Dingell ensures legal accountability. Such accountability exists in all other sectors of our society, yet we continue to exempt health plans.

Health plans are not currently held accountable for decisions about patient treatment that result in injury or death. Currently, ERISA preempts state laws and provides essentially no remedy for injured individuals whose health plans' decisions to limit care ultimately cause harm. If the plan was at fault, the maximum remedy is the denied benefit itself. Norwood-Dingell would remove ERISA's preemption and allow patients to hold health plans accountable according to state law. However, plans that comply with an external reviewer's decision may not be held liable for punitive damages. Additionally, any state law limits on damages or legal proceedings would apply.

My home State of Texas was the first State in the Nation to pass a patient protection act. But because many large employers insure their workers themselves, giving them Federal protection from State insurance laws under ERISA, only about 25 percent of Texans are covered by the act. It is fundamentally unfair to deny this group of individuals the rights my State has afforded to all other Texans who do not belong to an ERISA health plan. Norwood-Dingell would allow Texas' liability laws and patient protections to apply to all Texans.

The liability provision in Norwood-Dingell also protects employers from liability when they were not involved in the treatment decision. It explicitly states that discretionary authority does not include a decision about what benefits to include in the plan, or a decision not to address a case while an external appeal is pending or a decision to provide an extra-contractual benefit.

Now, I have heard a great deal of rumbling about the impact of Norwood-Dingell on health care costs. During the debate in the Texas Capitol, business and insurance groups routinely warned that costs would skyrocket. In fact, Texas' health insurance premiums continue to trail the rest of the country even though our fellow Texans enjoy some of the most stringent patients' rights laws in the country. Opponents said, repeatedly, that holding HMOs accountable for harming patients would provoke a flood of lawsuits. The reality is that no more than five suits have been filed since the law took effect in September 1997.

Instead of defending good, comprehensive, enforceable patients' rights legislation to insurance bureaucrats, we should be firing some questions of our own at the insurers. If managed care is supposed to make health care more affordable and therefore more available, why is it that, as HMO penetration increased in Texas, the percentage of working uninsured increased proportionately? Other than skyrocketing CEO compensation, where have all the millions of dollars in profits gone?

Mr. Chairman, it's time to stop the insurance companies from putting profits above patients. I urge my colleagues to vote for H.R. 2723, the Norwood-Dingell bipartisan managed care reform bill.

Mr. POMEROY. Mr. Chairman, I rise today in support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999.

Mr. Chairman, I believe that this legislation would ensure genuine accountability of health plans and put patient care ahead of profits. Today Congress has an historic opportunity to take steps to ensure that doctors and patients are in charge of health care decision-making.

I do have serious concerns, however, that the spending offsets originally designated in this legislation were not permitted under the rule. Managed care consumer protections must be enacted, but not while spending the surplus generated by the Social Security trust funds. While I support this legislation today, I certainly hope that spending offsets can be designated during the conference process, and I will not support a conference agreement that does not do so. Congress can and should ensure both quality health care and a secure retirement income for our nation's seniors.

Ms. KILPATRICK. Mr. Chairman, I rise today in strong support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act, also referred to as the Norwood-Dingell Act. We must help the poor, the uninsured, and all American citizens, in obtaining more accessible and more affordable health care. Over 60 percent of the U.S. population and over 75 percent of insured employees were covered by some form of managed care in 1997, and the numbers are growing. H.R. 2723, the Bipartisan Managed Care Improvement Act would enact important changes that are necessary to improve managed care.

Individuals should be assured that if they have a health emergency, the necessary services will be covered by their plan. The Bipartisan Consensus Act states, individuals must have access to emergency care, without prior authorization, in any situation that a ''prudent lay person'' would regard as an emergency. Patients with special conditions must have access to providers who have the requisite expertise to treat their problem. This Act allows for referrals for enrollees to go out of the plan's network for specialty care if there is no appropriate provider available in the network for covered services. It provides a process for individuals to select a specialist when they are seriously ill or require continued care by a specialist. It provides direct access to ob/gyn care and services, as well as access for children to pediatric specialists. The Bipartisan Consensus Act provides special protections for pregnancy, terminal illness, and individuals on a waiting list for surgery. The Act prohibits plans from gagging doctors regarding the discussion of treatment options with their patients. Consumers have the right to know all of their treatment options. In addition, patients should be protected against disruptions in care due to a change in plan or a change in a provider's network status.

The Bipartisan Consensus Act provides for a strong and efficient review process, using the insurer's internal appeals process, while ensuring that a health professional performs the review. If the patient is denied care in a decision by the plan's internal appeals process, they can then appeal to an external review body that is independent of the health plan. This review process should ensure excellent care, as grievances are effectively reviewed.

The Republican Health Care Access Bill does not improve health care access to those who most need improved access to health care. It does not improve the affordability of health care unless you have the extra cash to pay up front. It does not help our poor. It digs into our social security surplus by an estimated $48 billion over ten years. It does not improve access to preventative health care.

The Bipartisan Consensus Act protects patients and strengthens assurances that managed care programs will improve access to emergency care, specialists and doctor information on treatment options. Furthermore, the Act provides for an improved review process that works with current insurers' appeals processes. The Act is supported by doctors. It is supported by patients. And I support it. I urge my colleagues to join me in voting in support of the Bipartisan Consensus Managed Care Improvement Act. We must protect the health care needs of our patients and constituents, preserve social security, and ensure adequate access to health care for the poor.

Mr. FILNER. Mr. Chairman, I can't believe how beholden to special interests the majority is. We are presented with a bipartisan bill,

H.R. 2723, which is supported by the American Medical Association and 300 other organizations, yet the Republican leadership is trying to sink it.

Our bill offers vital patient protections in a way that has been shown to not raise costs. H.R. 2723 will return control of our health care to physicians. We, as patients, will have access to specialists and an appeals process. And managed care operations will be held accountable for any decisions that endanger our health. These important provisions must be embraced, not feared. Mr. Speaker, I urge support for H.R. 2723.

Mr. LARSON. Mr. Chairman, I rise today in support of a Patient's Bill of Rights. I had hoped, however, that an amendment version of Connecticut's Patient's Bill of Rights could have been considered. Unfortunately, the debate here has been hamstrung by the rules of the House, which makes it nearly impossible to have a policy debate on the issues, and prevents amendments from being offered that would enable the legislative process to respond to the primary concerns of patients.

In Connecticut, the Legislature demonstrated that if you work in a bi-partisan manner you can write legislation that is balanced, and gets to the heart of the matter, which is the protection for the patent, and thus, provide the care that is needed. Moreover, what most people don't understand is that under current law, HMOs can already be sued.

The vote today should be about a Patient's Bill of Rights, but in many respects it is about the tactical differences between various partisan proposals.

I remain committed to the fundamental principle that has guided me, which is that doctors and patients should determine how patients are treated and cared for, not bureaucrats. I have always tried to level the playing field for patients, and so has Connecticut.

The HMOs should be held accountable and liable for their actions without opening a Pandora's box of unlimited litigation. Companies in my home state of Connecticut have operated under the Connecticut law and are to be commended for their compliance. Connecticut has demonstrated that it can work.

Managed care is not without its problems, and we will need to work toward the goal of improvement. Fortunately, there are many fine people who represent the insurance industry who are working every day toward the goal, so that we can improve the health care delivery, control costs, and help the patient and family in time of need.

Ms. RIVERS. Mr. Chairman, while I plan to cast my vote today in favor of the protections given by the Patients Bill of Rights, I am greatly concerned with the partisan politics that have worked great mischief in the preparation of this proposal. Specifically, I condemn the House majority's manipulation of the rules process to exclude the funding mechanism advanced by the bipartisan sponsors of this bill. In light of this indefensible action by the opponents of the Patients Bill of Rights, H.R. 2723 comes before the House without compensatory new revenues or budget offsets attached to it. In short, it is unclear where the dollars to implement this bill will come from. And, inevitably, the cynical and strategically constructed attack of ''spending social security money'' will be leveled against those who vote in support of these protections. I cannot emphasize enough how dishonest, manipulative, and irresponsible the House majority strategy is. It puts a serious initiative support by the majority of Americans at risk for no other reason that partisan politics. This is among the most shameful things I have witnessed during my time in Congress.

I am voting yes on H.R. 2723 because I support the protections contained in it. I am not voting in favor of invading the Social Security Trust Fund. I have made a practice of voting against unfunded proposals, sham emergency spending, and budget gimmicks of all types. In this particular case, I firmly believe the Senate will not behave in the egregious manner of the House. I believe the Senate will attach appropriate funding to this bill before it returns to the House. If that is done, I will happily vote to send H.R. 2721 on to the President for his signature. If it is not done, I will unflinchingly vote against it.

Mr. DAVIS of Florida. Mr. Chairman, I rise today in strong support of the Bipartisan Consensus Managed Care Improvement Act, H.R. 2723. I commend Congressmen DINGELL and NORWOOD for putting aside partisan rhetoric and developing a bipartisan compromise designed to provide strong patient protections and to ensure that managed care companies are held accountable for their decisions.

As a member of the Florida House of Representatives, I played an active role in writing the Florida law on managed care. I remain a strong supporter of our managed care system of health care, but I believe that changes are needed to the current system to make the insurance companies accountable to their patients and that medical professionals rather than insurance companies' bureaucrats are making decisions on health care treatment.

The Norwood-Dingell bill provides strong patient protections, many of which have already been implemented in states throughout this country, including my home state of Florida. I applaud these very needed protections. However, the focus of this bipartisan bill is by far its emphasis on holding managed care companies accountable for medical treatment decisions through a new independent review process and providing patients access to state courts to ensure the enforcement of the decisions of the independent review panel. The Norwood-Dingell bill is the only option available to this House that will remove the preemption currently given to managed care health plans covered under the Employee Retirement and Security Act (ERISA).

Throughout the debate on managed care reform, we have all heard extensive arguments about the impact that providing patients the right to hold their health plans accountable will have on monthly premiums. I do not believe, however, that monthly health insurance premiums will significantly increase as a result of passage of the Bipartisan Consensus Managed Care Improvement Act of 1999. The liability provisions contained in this legislation are very similar to those included in a law passed by the State of Texas. In the two years since the enactment of their managed care law, Texas has experienced only minor increases in health insurance premiums.

We have also heard that if we pass any liability provisions our court dockets will explode as patients rush to sue their managed care plans. Again, I refer to the experience in Texas—where in the last two years only five lawsuits have resulted from their law allowing patients to hold their managed care plans accountable. Let me repeat that statistic, from over four million Texans who are covered by health maintenance organizations (HMOs) only five lawsuits have been filed as a result of the Texas managed care law.

I think it is commendable that unlike the tactics in this body, the Texas Legislature rose above partisan politics and worked in a bipartisan manner to ensure the safety of their citizens participating in managed care plans.

I urge my colleagues to think of our constituents who are being denied treatment for very serious illnesses. I urge you to think of our constituents who are seriously injured or die as a result of an insurance company clerk either denying or delaying necessary medical treatment.

I strongly urge my colleagues to support meaningful managed care reform. Support the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act.

Mrs. MINK of Hawaii. Mr. Chairman, I rise to express my support for H.R. 2723, the ''Bipartisan Consensus Managed Care Improvement Act of 1999.''

Everyone should feel confident and assured that their managed care organization will fulfill what is perceived by the general public to be basic and reasonable health coverage in times of need. However, what patients consider reasonable, has often been called unjustified or unnecessary by health plans. These frequent disputes have resulted in a stream of cases where patients and their families are forced to jump through hoops, chase carrots, and fight tooth and nail, for benefits they felt they outright deserved in the first place. This is wrong.

H.R. 2723 establishes basic rights for patients when dealing with managed care organizations and will help to restore public confidence and trust in their doctors and health care professionals. The bill will facilitate patients' access to care, improve doctor-patient relationships, provide patients with defined rights to appeal coverage denials, and hold health plans accountable for erroneous coverage decisions that have adverse effects on patients' health.

First, the Bipartisan Consensus Managed Care Improvement Act tears down barriers to health care access. The bill requires plans to improve access by providing coverage for services that the general population commonly feels to be the most basic of benefits but plans often fail to provide. These benefits include: emergency care in any hospital emergency room, including outside of the health plan, and without prior authorization; access to specialists for patients with special conditions; access to outside specialists if none are available in the plan; the option of going outside of the plan for care as long as the patient agrees to pay any additional costs; and permitting patients with special conditions to have continued access to their specialists when the plan terminates the specialists or the plan is terminated.

The bill further improves access by eliminating prerequisites of going through a gatekeeper before seeing certain specialists. Specifically, women will have direct access to Ob-Gyns and children could have pediatricians as their primary care providers. This will eliminate the burdensome and often unnecessary step of visiting a general practitioner for something that should obviously be handled by one of these specialists.

Furthermore, H.R. 2723 will facilitate patients' access to the latest health care treatments. It requires health plans to: allow patients to participate in clinical trials while the health plan pays for routine patient costs associated with the trials; and provide access to medications that are not on the plan's drug formulary when it is prescribed by a physician.

Second, the bill would restrict certain managed care plan practices that interfere with doctor-patient relationships. Health plans would be prohibited from: restricting health professionals from advising a patient about a treatment option regardless of whether the plan covers the treatment; providing doctors with incentives to limit medically necessary services; and from retaliating against health care professionals who advocate on behalf of patients or disclose information about quality of care to regulatory or accrediting agencies. Freeing doctors and health professionals from these pressures imposed upon by health plans will enable them to practice medicine as it should be, without outside intervention.

Third, the bill would provide patients with appeal rights when coverage for treatment is denied. Health plans would be required to meet certain guidelines when considering treatment authorizations and provide patients and their families with specific appeal options. If coverage is denied, the bill provides for internal appeal processes involving a health professional, who was not involved in the original decision, followed by an external appeals process based on objective standards of professional medical practice. The bill sets time limitations on how long the plan can take to render a decision in each step of the appeal process and requires that the reasons for the denial be communicated to the patient. Patients and their families are too often bewildered by the complex procedures they must endure to obtain coverage for care they thought was included in their health care insurance. These new rights will provide relief to all families in these situations and will accelerate the appeals process.

Finally, the bill would enable patients who are wrongfully denied care by health plans governed by the Employee Retirement Income Security Act (ERISA) to sue their plan for damages. Persons in such situations currently may only sue to recover the cost of the care but not for damages. It is time that health plans be held accountable for the adverse effects their decisions have on patients' health and lives.

I have always felt that health plans should not impede access to health care but rather they should facilitate it. H.R. 2723 will provide patients with the basic rights necessary to assure that they are treated fairly when dealing with managed care organizations. No one in the United States should ever again be forced to face managed care organizations without these rights and I urge immediate passage of H.R. 2723, the ''Bipartisan Consensus Managed Care Improvement Act of 1999.''

Mr. MORAN of Virginia. Mr. Chairman, I rise in strong support of the Dingell-Norwood bill and in opposition to the substitute alternatives. I am not going to address the specifics of the bill because I am confident my colleagues will do a good job of that but instead I want to just share with you the kind of trauma that I hope this bill will address.

I received a letter from one of my constituents, a police officer in Alexandria, who was compelled to write about her problems with her own managed care company. ''The entire ordeal was hideous.'' she wrote. Kris Gulden suffered a spinal chord injury in an accident which resulted in paralysis below the waist. After the accident, Kris began the grueling work of occupational and physical therapy that can make such a difference in quality of life. Her therapists told her that her hard work was paying off and that more therapy could continue to make a difference. Unfortunately, her managed care company disagreed. They refused to extend the standard 90 days of coverage through their internal appeals process because it was a ''quality of life issue'' and not a ''life and death issue.'' Kris appealed as many times as she could through the managed care organization's internal appeals and then had no further recourse.

Fighting over late bills and arguing with the managed care company became the focus of her life when she should have been focusing on exercise and therapy that would have made her stronger. Fortunately, Officer Gulden has a compassionate employer in the City Manager of Alexandria who helped her deal with the unpaid bills, and a compassionate family and community who helped her raise additional money for further therapy. But she wrote because she doesn't want to see the same thing happen again to anyone. ''It's ridiculous that what most prevented me from getting better was my HMO.'' she wrote:

> Not being able to walk, not being able to stand up to take a shower, living with abnormal bowel and bladder function . . . in general, living with a disability is a walk in the park compared to what they put me through. Truly, dealing with them has been the worst part of this whole ordeal.

Finally, the most important point of Kris' letter was to say that ''I am vehemently opposed to any compromise on the Patient's Bill of Rights.'' I close by asking my colleagues to do what Kris, and so many of our constituents like her wish. I urge you to support the Dingell-Norwood bill without amendment.

Mr. VENTO. Mr. Chairman, I rise today in support of H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999. I'm pleased to have joined as a cosponsor of this measure, which acknowledges that all Americans deserve a strong standard of protection in managed care and other health insurance programs.

There is general agreement that managed care reform should address the fundamental concerns of all American families that have health insurance. Access to specialty care, emergency care, clinical trials and continuity of care are just a few of the widely lauded provisions of this proposal. In addition to these core access provisions, H.R. 2723 will also ensure that medical judgments are made by medical experts.

Although managed care has played an important role in helping to efficiently utilize finite health care resources, managed care policy needs more balance and accountability. It is time for Congress to remove the current ERISA shield and permit the judicial system process to hold health care plans fully responsible for their negligent decisions and actions whether intra stat or interstate health insurance.

Mr. Chairman, meaningful reform should include meaningful protections. Only a national policy can address the deficiencies of current law, which leaves too many patients without adequate recourse. While critics portray this legislation as the precursor to a proliferation of capricious lawsuits, I have more faith that the American public and legal system which are interested foremost in timely and appropriate medical care, not litigation. We need not invent a new medical police force, rather just permit the time tested legal system and rights of the individual to reasonable due process.

Health care consumers should have aces to necessary medical treatment, as well as objective remedies if a health plan decision is alleged to cause harm. During a time of unprecedented prosperity, H.R. 2723 reaffirms that equity and quality should be the unquestioned foundation of our health care system. I urge my colleagues to support this sound managed care reform proposal encompassed in the Dingle-Norwood measure and as we defeat the gauntlet of amendments and detours to sound health insurance finally vote to pass the base bill, the patients healthcare bill of rights.

Mr. MCGOVERN. Mr. Chairman, I rise today in strong support of the Norwood/Dingell Bipartisan Consensus Managed Care Improvement Act.

Today we are debating a very simple issue: whether we will provide the proper protection for patients who pay good money for their health insurance. We have all heard the horror stories from patients, doctors, nurses and employers about the need to improve basic HMO coverage. This bill will do that.

We are addressing basic rights that patients should receive from their health plan—the right to appeal to an external review panel, the right to have access to a gynecologist or other specialist, and the right to hold an HMO accountable for its decisions. The Norwood/Dingell bill provides the strongest patient protections and holds HMOs accountable for their actions, just like doctors. The Republican amendments offered today are insurance protection bills and do not protect the patient.

The bottom line must not dictate the amount or quality of car a patient receives. Profit margins should not dictate whether an injured person can go to the emergency room or visit a medical specialist. This bill will ensure that patients receive the best care and coverage from their HMO. We owe our constituents nothing less.

Mr. Chairman, I urge my colleagues to support this bill, vote against the poison pill substitutes and vote for Norwood/Dingell.

Mr. BENTSEN. Mr. Chairman, I rise today to express my strong support for H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 or the Patient's Bill of Rights, that is sponsored by Representative NORWOOD and Representative DINGELL. Today, we will consider four different approaches to reform managed health care plans. I am a strong supporter and co-sponsor of H.R. 2723 because I believe that this bill provides essential consumer protections to all Americans. I urge my colleagues to reject all three versions of the Republican Leadership sponsored legislation, and vote for the real Patients' Bill of Rights.

Today, there are more than 160 million Americans enrolled in managed care plans, such as Health Maintenance Organizations (HMOs). Of these enrollees, approximately 125 million Americans are enrolled in managed care health plans that are governed by federal law, the Employee Retirement and Insurance Security Act (ERISA). Under ERISA,

these Americans cannot seek legal remedy if their health plans denies or delays access to care. In a time when many Americans believe that their health plans are arbitrarily denying care and services, the Norwood-Dingell bill would ensure that health plans must provide an appeals process to their decisions. Under the Norwood-Dingell bill, patients would be guaranteed the right to seek both an internal and external appeals process with a deadline for decisions to be made. If both of these appeals are denied, consumers would have the right to hold their plans accountable for their decisions through a legal case in our court system. In my state of Texas, where a state law has been in effect for two years, our experience has been that these external reviews have been decided on behalf of consumers in 50 percent of these cases, while the rest of these cases have been decided on behalf of the health plans. We have also seen that very few consumers have decided to use their new right to sue, with very few lawsuits filed to date.

The Norwood-Dingell bill provides critical reforms that patients need. It guarantees that decisions will remain in the hands of doctors and nurses, not insurance companies. It guarantees access to specialists and ensures that doctors and nurses can talk freely with patients without interference from their health plans. The Norwood-Dingell bill also prohibits the use of financial incentives to limit medical care. The Norwood-Dingell bill also ensures that patients can seek care in emergency rooms without prior approval and when they are suffering severe pain.

I would like to highlight one main difference between these bills. The Norwood-Dingell bill also includes an important provision to ensure that all Americans can enroll in cutting-edge cancer clinical trials if they need them. As the sponsor of legislation to ensure that Medicare beneficiaries can enroll in cancer clinical trials, I believe we must guarantee this right to ensure that patients have access to the best, most-advanced care. As the Representative for the Texas Medical Center, where many of these cancer clinical trials are conducted, I believe that this guarantee must be included as any consumer-protection. The Norwood-Dingell bill would require managed care plans to pay for the routine costs associated with cancer clinical trials.

I wish to be clear why I opposed the House Rule that was imposed by the Republican majority on this bill. This rule was fatally flawed in many respects. Most important was its failure to include offsetting provisions to pay for the costs associated with this bill. This is important because it would ensure that this bill if fully paid and would not add to the on-budget deficit. I will be supporting final passage of H.R. 2723 in order to ensure that this federal uniform consumer protections will be provided to managed care enrollees. I am pleased to note President Clinton's letter of October 7 in which he states that he will not sign a bill whose costs are not fully offset. Indeed, it is my hope during the conference process that these offsetting provisions can be added to this necessary bill. It is my understanding that the Senate bill on managed care reform legislation already includes these offsetting provisions and therefore this issue could be addressed as part of the conference process.

I also opposed the rule because it linked final passage of H.R. 2723 to another bill, H.R. 2990, a bill providing new tax deductions for health care costs. Although I support many provisions included in H.R. 2990, such as providing 100 percent tax deductibility for health insurance costs for self-employed persons, yesterday I opposed H.R. 2990 because of several provisions included in H.R. 2990 such as Association Health Plans (AHPs). These AHPs plans would not be subject to state insurance regulations or to the federal ERISA law. I am concerned that we would be establishing a loophole for employers to create health insurance plans without adequate regulations and solvency standards. Although I will support final passage of these two combined bills if the Norwood-Dingell bill remains in tact, I want to express my strong concern that this tax legislation should not have been linked to the Patient's Bill of Rights, I would have preferred that these two bills were considered separately, on their own merits. However, we in the House of Representatives will not have this option.

I urge my colleagues to reject the three Republican alternative bills and vote for the Bipartisan Managed Care Improvement Act.

Mr. DIXON. Mr. Chairman, I rise in strong support of H.R. 2723, the Dingell-Norwood Bipartisan Consensus Managed Care Improvement Act of 1999, and in opposition to the substitute amendments being offered. I am proud to be a cosponsor of this important legislation, which will protect consumers in managed care plans.

I have heard from many residents of California's 32nd Congressional district as they become increasingly skeptical of the motives behind the treatment decisions made by their health plans and fearful of the consequences of those decisions. Fortunately, the accountability provisions in the Dingell-Norwood bill will allow patients to hold health plans liable when a decision about patient treatment results in injury or death. At the same time, the bill protects employers who provide health insurance from liability when they are not involved in medical treatment decisions.

The Dingell-Norwood bill ensures that health care decisions are made by medical experts, not insurance company administrators. The bill offers protection important to my constituents, including access to needed health care specialists, assurance that doctors and patients can openly discuss treatment options, and access to a timely internal and external appeals process when a health plan denies or delays doctor-prescribed care.

Mr. Chairman, the Dingell-Norwood bill is an excellent, bipartisan response to the problems facing health care consumers. The substitute measures masquerading as patients' rights legislation which will be offered by opponents of this bill do not offer Americans the patient protection they are asking for in their managed care plans. The House cannot squander this chance to pass meaningful managed care reform legislation; it is essential that we pass the Dingell-Norwood bill and reject any attempt to weaken its important provisions.

Mr. CAPUANO. Mr. Speaker, I rise in support of The Bipartisan Consensus Managed Care Improvement Act of 1999 sponsored by Representatives NORWOOD and DINGELL. This bill modeled after the Democratic Patient Bill of Rights, would ensure strong patient protections for people enrolled in Health Maintenance Organizations.

I strongly oppose efforts by the Republican leadership to dictate the debate by promoting a rule that is designed to kill the Norwood-Dingell reform bill. I urge my colleagues to oppose the rule as it attaches the Quality Care for the Uninsured Act to the managed care bill. While I support its intent to reduce the number of Americans who are currently without health insurance, the tax breaks contained in the legislation benefit the wealthy and would have little effect on working Americans who have no health insurance. According to the General Accounting Office, more than 32 million of the uninsured fall within the 0–15 percent income tax brackets. These tax deductions would do nothing to help them. H.R. 2990 is a poison pill that must be defeated.

The Bipartisan Managed Care Improvement Act of 1999 stands in stark contrast to H.R. 2990. H.R. 2723 offers real managed care reform by providing a comprehensive, enforceable set of consumer rights. Under current federal law, patients covered by private employer-sponsored health insurance are barred from suing health plans for damages caused by wrongful denials. No other industry enjoys such legal immunity. H.R. 2723 would close this loophole by giving consumers the right to sue health plans in state courts for injuries and deaths caused by improper denials of care. Furthermore, the bill guarantees patients' access to such critical services as emergency care, specialty care, clinical trials, as well as obstetrician and gynecological services for women. The Norwood-Dingell reform plan also would allow patients to choose their health plans and ensure the continuity of care when people change jobs.

It is time for Congress to address the issue of managed care reform. I have heard time and time again from my constituents in Massachusetts who support these rational HMO reforms that are designed to hold these organizations accountable for bad decisions. The Norwood-Dingell proposal represents an important step in overhauling managed care and enabling patients and their doctors to regain control of critical medical decisions. Doctors and patients know best—not HMO bureaucrats. I urge my colleagues to vote in favor of H.R. 2723 and pass meaningful managed care reform.

Mr. DOYLE. Mr. Chairman, I rise today in strong support of true and meaningful managed care reform that H.R. 2723 provides to all Americans. On behalf of my constituents back in Western Pennsylvania, I am proud to say I am a cosponsor of this vital bipartisan legislation which confronts the real problems many families face with HMO's

My colleagues, supporting this bill is the only responsible choice for us to make certain that everyone in America has proper access to medical care, can see a medical specialist when necessary, and will ensure timely access to emergency room care.

The Bipartisan Managed Care Improvement Act guarantees medical decisions are made by qualified health care professionals, and not by insurance company bureaucrats. It returns to the American people that which has been denied for too long; the right to hold managed care companies accountable if they choose to make decisions regarding medical treatment.

Lately, there has been much concern expressed regarding employer liability provision in this bill. The overwhelming majority of employers rely on a third-party health plan to make medical decisions. Under our bill, only organizations that make negligent medical

treatment decisions on individual claims are subject to liability. Independent legal analyses have confirmed that employer liability allegations are simply a non-issue. Managed care and insurance company bureaucrats have to stop shunning responsibility and realize that if they choose to make harmful discretionary treatment decisions, they will be held accountable by the public.

Most importantly, our bill would help all American families, like my constituent Ellen Gasparovic, who was diagnosed with breast cancer, only to have her HMO refuse to pay to have the cancerous lumps removed from her chest. Fortunately, Mrs. Gasparovic is doing well today, but only after having to endure needless financial and emotional hardships, all because of the negligence of her HMO.

It is on behalf of my constituents in Western Pennsylvania that I urge my colleagues to support H.R. 2723, and defeat any attempts to weaken this much needed legislation.

Mr. SANDLIN. Mr. Chairman, the insurance companies are at it again. They are trying to deceive the American public and in the process are attempting to take away a fundamental right of each and every American.

Clearly, a right without a remedy is absolutely meaningless. The Norwood-Dingell bill comes down to one word—Fairness. This bipartisan bill guarantees patient protections such as the right to choose the doctor that best serves your needs; the right to have medical decisions made by physicians and their patients, not HMO bureaucrats interested in the bottom line; the right to know that our families will be able to use the emergency room when needed; the right to obtain the information we need to make informed decisions about our own medical care.

But what if our families are denied medical service? What if a delay in a service causes harm to our children, our spouses, our parents, our families? Where is the fairness then?

The Norwood-Dingell bill would allow patients (or the estates of patients) who are injured or die as a result of their health plan's denial of care to sue the health plan in State courts for damages. This is what the real world calls accountability. That's fairness.

As a strong supporter of local control, I support the Norwood-Dingell bill because, unlike the Coburn-Shadegg substitute, it will not override protections already enacted by the states. These protections in state laws are currently applicable to all non-ERISA employer-sponsored health insurance and to individually purchased insurance. It is not fair that these protections afforded by the states to their residents, do not have the force of law for everyone in the state. The Norwood-Dingell bill would restore those protections to everyone by removing the preemption provision in ERISA so that state laws prevail.

In contrast, Coburn-Shadegg would continue to preempt state liability law with respect to health plans and insurers. Rather than maintain the states' traditional role in regulating insurance by allowing state causes of action, Coburn-Shadegg creates an entirely new federal cause of action.

Mr. Chairman, federal courts are already overburdened, particularly in light of the fact that the Republican majority in the other body refuses to confirm President Clinton's nominations to the bench, creating more than 50 vacancies in the federal courts. In addition to this obstacle, patients seeking redress for injury or death will have to wait in line behind drug dealers and thieves because the Speedy Trial Act of 1974 gives criminal cases priority in the federal court docket. Those criminal cases should be given priority because that's where they belong—in federal courts. Liability suits against HMOs, however, belong in state courts.

In my home state of Texas, we have 372 state courts, but only 39 federal courts. Obviously, Coburn-Shadegg creates so many barriers to a trial that patients will never want to exercise the right we are trying to give them. The Norwood-Dingell bill is the only bill that restores states' rights and provides patients with real protections under the law.

Will there be a flood of litigation if Norwood-Dingell is enacted? Hardly. In Texas, we enacted a law in 1997 creating an external appeals process and allowing lawsuits against HMOs. In the two years since that law took effect, only five lawsuits have been filed against health plans in Texas. That's five lawsuits in two years—hardly an explosion.

And contrary to all the allegations, there is no employer liability in the Norwood-Dingell bill. Clearly, employers cannot be held liable for the decisions of insurance companies and/or the decisions of others. This bill does not create a new cause of action. It simply removes the provision of ERISA that protects insurance companies from being sued. It specifically states that employers cannot be held liable unless they exercise discretionary authority—in other words, if the employer acts like a doctor and makes a medical decision on an employee's claim for benefits covered under the plan, then the employer must accept the accountability that comes along with playing doctor.

I should point out that I have met with many representatives of the business community and I have repeatedly asked them to bring language to me that they believe would prevent employers from being sued. I assured them that I would work with Mr. DINGELL and Mr. NORWOOD to address their concerns. Not one of those people has taken me up on my offer. That is because there is no employer liability in the bill. Their answer instead is to oppose the entire bill and threaten Members who support Norwood-Dingell.

So why are the insurance companies so worried about the liability provisions of Norwood-Dingell? Because legal accountability will force HMOs to provide quality care, and some insurance company bean counters are afraid that might mean a smaller profit margin for them. They argue that Norwood-Dingell would force managed care plans to practice defensive medicine that would increase their costs and cause them to raise our premiums. This argument is ridiculous and actually underlines the need for reform. Norwood-Dingell specifically provides that plans are not required to cover any services beyond those provided in the contract. So with the liability provision in place, costs of care should not increase significantly as these costs are already covered by premiums. Care is being paid for, but not provided. Legal accountability will give HMOs the incentive to provide a quality of care that patients have every right to expect.

Mr. Chairman, I urge my colleagues to support the Norwood-Dingell bill and reject this disingenuous attempt by insurance companies to pull the wool over the eyes of the American people.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. PEASE) having assumed the chair, Mr. HASTINGS of Washington, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, pursuant to House Resolution 323, he reported the bill, as amended pursuant to that rule, back to the House.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

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

RECORDED VOTE

Mr. JOHN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 275, noes 151, not voting 8, as follows:

[Roll No 490]

AYES—275

Abercrombie	Coburn	Gibbons
Ackerman	Condit	Gilchrest
Allen	Conyers	Gilman
Andrews	Cook	Gonzalez
Bachus	Cooksey	Gordon
Baird	Costello	Graham
Baldacci	Coyne	Green (TX)
Baldwin	Cramer	Greenwood
Barcia	Crowley	Gutierrez
Barr	Cummings	Hall (OH)
Barrett (WI)	Danner	Hall (TX)
Bateman	Davis (FL)	Hastings (FL)
Becerra	Davis (IL)	Hefley
Bentsen	Davis (VA)	Hill (IN)
Berkley	DeFazio	Hilliard
Berman	DeGette	Hinchey
Berry	Delahunt	Hinojosa
Bilbray	DeLauro	Hoeffel
Bilirakis	Deutsch	Holden
Bishop	Diaz-Balart	Holt
Blagojevich	Dicks	Hooley
Blumenauer	Dingell	Horn
Boehlert	Dixon	Hoyer
Bonior	Doggett	Hunter
Bono	Dooley	Hyde
Borski	Doyle	Inslee
Boswell	Duncan	Jackson (IL)
Boucher	Edwards	Jackson-Lee (TX)
Boyd	Engel	Jefferson
Brady (PA)	Eshoo	Jenkins
Brady (TX)	Etheridge	John
Brown (FL)	Evans	Johnson, E. B.
Brown (OH)	Farr	Jones (NC)
Callahan	Fattah	Jones (OH)
Canady	Filner	Kanjorski
Cannon	Foley	Kelly
Capps	Forbes	Kennedy
Capuano	Ford	Kildee
Cardin	Frank (MA)	Kilpatrick
Carson	Franks (NJ)	Kind (WI)
Castle	Frelinghuysen	King (NY)
Chambliss	Frost	Kleczka
Clay	Gallegly	Klink
Clayton	Ganske	Kucinich
Clement	Gejdenson	LaFalce
Coble	Gephardt	

Lampson
Lantos
Larson
LaTourette
Leach
Lee
Levin
Lewis (GA)
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McHugh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Phelps
Pickett
Pomeroy
Porter
Price (NC)
Quinn
Rahall
Rangel
Reyes
Reynolds
Rivers
Rodriguez
Roemer
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Rush
Sanchez
Sanders
Sandlin
Sawyer
Saxton
Schakowsky
Scott
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shows
Sisisky
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Spence
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Sweeney
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thornberry
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Vitter
Walsh
Wamp
Waters
Watt (NC)
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Weygand
Wilson
Wise
Wolf
Woolsey
Wu
Wynn
Young (FL)

NOES—151

Aderholt
Archer
Armey
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bass
Bereuter
Biggert
Bliley
Blunt
Boehner
Bonilla
Bryant
Burr
Burton
Buyer
Calvert
Camp
Campbell
Chabot
Chenoweth-Hage
Collins
Combest
Cox
Crane
Cubin
Cunningham
Deal
DeLay
DeMint
Dickey
Doolittle
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Fossella
Fowler
Gekas
Gillmor
Goode
Goodlatte
Goodling
Goss
Green (WI)
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Hostettler
Houghton
Hutchinson
Isakson
Istook
Johnson (CT)
Johnson, Sam
Kasich
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
Lazio
Lewis (CA)
Lewis (KY)
Linder
Lucas (OK)
Manzullo
McCrery
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Myrick
Nethercutt
Ney
Northup
Nussle
Ose
Oxley
Packard
Paul
Pease
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Pryce (OH)
Radanovich
Ramstad
Regula
Riley
Rogan
Rogers
Rohrabacher
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Schaffer
Sensenbrenner
Shadegg
Shimkus
Simpson
Skeen
Smith (MI)
Smith (TX)
Souder
Stearns
Stump
Sununu
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thune
Tiahrt
Toomey
Upton
Walden
Watkins
Watts (OK)
Weller
Whitfield
Wicker
Young (AK)

NOT VOTING—8

Clyburn
Granger
Hulshof
Kaptur
Portman
Sabo
Scarborough
Shuster

□ 1641

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. CLYBURN. Mr. Speaker, I was unavoidably detained in a meeting of the Committee on Standards of Official Conduct. Had I been present on the vote, I would have voted in favor.

Mr. SABO. Mr. Speaker, I was detained by the previously mentioned in a meeting of the Committee on Standards of Official Conduct. If I had been present, I would have voted ''yes.''

Stated against:

Mr. PORTMAN. Mr. Speaker, I was detained in a meeting with the Committee on Standards of Official Conduct during the vote on the Norwood-Dingell legislation. Had I been present, I would have voted ''no.''

Mr. HULSHOF. Mr. Speaker, I was detained in the very same meeting of the Committee on Standards of Official Conduct during the vote on the Dingell legislation. Had I been present, I would have voted ''no.''

PERMISSION TO HAVE UNTIL MIDNIGHT, FRIDAY, OCTOBER 8, 1999, TO FILE CONFERENCE REPORT ON H.R. 2561, DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2000

Mr. LEWIS of California. Mr. Speaker, I ask unanimous consent that the managers on the part of the House may have until midnight, Friday, October 8, 1999, to file the conference report on the bill (H.R. 2561) making appropriations for the Department of Defense for the fiscal year ending September 30, 2000, and for other purposes.

The SPEAKER pro tempore (Mr. PEASE). Is there objection to the request of the gentleman from California?

There was no objection.

LEGISLATIVE PROGRAM

(Mr. MENENDEZ asked and was given permission to address the House for 1 minute.)

Mr. MENENDEZ. Mr. Speaker, I yield to the gentleman from New York (Mr. LAZIO) for an explanation of next week's schedule.

Mr. LAZIO. Mr. Speaker, I am pleased to announce that we have completed legislative business for the week. The House will meet for a pro forma session tomorrow. Of course, there will be no legislative business and no votes tomorrow.

The House will meet again on Tuesday, October 12, at 12:30 p.m. for morning hour and at 2 p.m. for legislative business. We will consider a number of bills under suspensions of the rules, a list of which will be distributed to Members' offices tomorrow. On Tuesday, we do not expect recorded votes until 6 p.m.

On Wednesday, October 13, and the balance of next week, the House will take up the following measures which will be subject to rules: H.R. 1993, the Export Enhancement Act, and the Department of Labor, Health and Human Services and Education Appropriations Act. We also expect a number of appropriations conference reports to become available for consideration in the House early next week, but possibly throughout the entire week.

□ 1645

Mr. Speaker, on Friday, October 15, no votes are expected after 2 p.m. I just want to wish all of my colleagues happy Columbus Day weekend, and pray that everybody has a safe travel back, and that they have an opportunity to celebrate the discovery of Columbus, that great Italian American.

Mr. MENENDEZ. Mr. Speaker, I thank the gentleman, and I would ask him if he would be able to answer a question or two about the schedule. We certainly all wish our colleagues a safe journey and a good Columbus day celebration.

Mr. Speaker, does the gentleman expect any late nights next week, in view of the schedule as the gentleman has announced it? And in terms of our effort to make this place family-friendly, does the gentleman expect any late nights next week?

Mr. LAZIO. If the gentleman will yield further, it looks as though we will have no late nights next week. We expect to have our business concluded relatively early.

Mr. MENENDEZ. I thank the gentleman. That would be helpful to our families.

We have heard about a November schedule from some of our colleagues on the other side who are wondering, and we are wondering, when that might be available to the minority so that Members can plan. If our expectation is to be here in November, we would like to know that schedule as well, if the gentleman would be so kind as to respond.

Mr. LAZIO. If the gentleman would continue to yield, Mr. Speaker, right now it is the expectation of the Speaker of the House that the House will adjourn October 29, so the target adjournment still is in this month. Of course, anything is possible as we struggle through these last few weeks in the appropriations cycle.

As soon as we have additional information, we would be happy to share it with the gentleman. Right now, the target adjournment date continues to be October 29.

Mr. MENENDEZ. We certainly all hope that we can achieve an agreement on our budgetary needs by that time.