As an illustration of this point, enclosed is an article recently published in our Community Transportation magazine that discusses public transportation as part of the solution to traffic congestion and mobility issues in Acadia, Yosemite and Zion National Parks. These success stories could be replicated in many other communities under your Transit in Parks proposal.

We (Dale J. Marsico) commend your dedicated efforts and initiative in this regard, and look forward to helping you advance this important piece of legislation.

Sincerely,

Dale J. Marsico
Executive Director

**AMENDMENTS SUBMITTED AND PROPOSED**

**SA 831. Mr. BOND (for himself, Mr. ROBERTS, and Mr. HELMS) proposed an amendment to the bill S. 1052, to amend the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table.**

**SA 832. Mr. FRIST (for himself, Mr. BREAUX, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 1052, supra.**

**SA 833. Mr. WARNER proposed an amendment to the bill S. 1052, supra.**

**SA 834. Ms. SNOWE (for herself, Mrs. LINCOLN, Mr. DWYER, Mr. NELSON, of Nebraska, Mr. SPECKER, Mr. MCCAIN, Mr. BAUCUS, Ms. STABENOW, and Mr. CRAFIER) proposed an amendment to the bill S. 1052, supra.**

**SA 835. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.**

**SA 836. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.**

**SA 837. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.**

**SA 838. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, supra; which was ordered to lie on the table.**

**SA 839. Mrs. HUTCHISON (for herself and Mrs. CLINTON) submitted an amendment intended to be proposed by her to the bill S. 1052, supra.**

**SA 840. Mr. ENZI proposed an amendment to the bill S. 1052, supra.**

**SA 841. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.**

**SA 842. Mr. DWYER submitted an amendment intended to be proposed by him to the bill S. 1052, supra.**

**SA 843. Mr. GRAMM (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1052, supra.**

**SA 844. Mr. SPECKER proposed an amendment to the bill S. 1052, supra.**

**SA 845. Mr. GRASSLEY proposed an amendment to the bill S. 1052, supra.**

**SA 846. Mr. NICKLES (for himself and Mr. ESSEND) proposed an amendment to the bill S. 1052, supra.**

**SA 847. Mr. BROWNBACK proposed an amendment to the bill S. 1052, supra.**

**SA 848. Mr. ESSEND proposed an amendment to the bill S. 1052, supra.**

**SA 849. Mr. ESSEND proposed an amendment to the bill S. 1052, supra.**

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**TEXT OF AMENDMENTS**

**SA 831. Mr. BOND (for himself, Mr. ROBERTS, and Mr. HELMS) proposed an amendment to the bill S. 1052, to amend the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:**

On page 154, between lines 2 and 3, insert the following:

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"(11) MINIMUM SHARE OF SETTLEMENT OF AWARD—
"(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorney's fees from the total amount of such award.

"(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought under this subsection is less than $100,000.

"(C) DEFINITIONS.—In this paragraph:
"(aa) final court decision;
"(bb) court order;
"(cc) settlement agreement;
"(dd) arbitration procedure; or
"(ee) alternative dispute resolution procedure (including mediation); less
"(II) any reimbursement for any expenses incurred in connection with such representation or work.

"(12) AWARD.—The term 'award' means the sum of—

"(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

"(aa) final court decision;
"(bb) court order;
"(cc) settlement agreement;
"(dd) arbitration procedure; or
"(ee) alternative dispute resolution procedure (including mediation); plus
"(II) any attorney's fees awarded under subsection (g)(1) with respect to the participant or beneficiary (or estate) under this subsection.

"(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorney's fees from the total amount of such award.

"(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

"(aa) final court decision;
"(bb) court order;
"(cc) settlement agreement;
"(dd) arbitration procedure; or
"(ee) alternative dispute resolution procedure (including mediation); plus
"(II) any attorney's fees awarded under subsection (g)(1) with respect to the participant or beneficiary (or estate) under this subsection.

"(C) DEFINITIONS.—In this paragraph:
"(aa) final court decision;
"(bb) court order;
"(cc) settlement agreement;
"(dd) arbitration procedure; or
"(ee) alternative dispute resolution procedure (including mediation); less
"(II) any reimbursement for any expenses incurred in connection with such representation or work.

"(2) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 105, line 2, after ‘‘treatment’’ insert the following: ‘‘The name of the designated decision-maker (or decision-makers) appointed under section 502(b)(2)(A) of the Employee Retirement Income Security Act of 1974 for purposes of making final determinations under section 103 and approving coverage pursuant to the written determination of an independent medical reviewer under section 104.’’

Beginning on page 139, strike line 21 and all that follows through line 14 on page 171, and insert the following:

**SEC. 302. 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:

"(i) CAUSE OF ACTION RELATING TO DENIAL OF A CLAIM FOR HEALTH BENEFITS.—

"(A) FAILURE TO COMPLY WITH EXTERNAL MEDICAL REVIEW.—With respect to an action brought by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decision-maker described in paragraph (2) fails to exercise ordinary care in approving coverage pursuant to the written determination of an independent medical reviewer under section 104(d)(3)(F) of the Bipartisan Patient Protection Act that reverses a denial of the claim for benefits; and

''(ii) the failure described in clause (i) is the proximate cause of substantial harm (as defined in paragraph (10)(G)) to the participant or beneficiary;

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such designated decision-maker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

"(B) WRONGFUL DETERMINATION RESULTING IN DELAY IN PROVIDING BENEFITS.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

(i) a designated decision-maker described in paragraph (2)—

(I) fails to exercise ordinary care in making a determination denying the claim for benefits under section 102 of the Bipartisan Patient Protection Act (relating to an initial claim for benefits); or

(II) fails to exercise ordinary care in making a determination denying the claim for benefits under section 103 of such Act (relating to an initial claim for benefits); or

(ii) the denial described in clause (i) is reversed by an independent medical reviewer under section 104(d) of such Act, or the coverage for the benefit involved is approved after the denial is referred to the independent medical reviewer but prior to the determination of the reviewer under section 103 of such Act; and

(iii) the attributable failure to the attribute described in clause (i) is the proximate cause of such failure to, or the wrongful death of, the participant or beneficiary; such designated decision-maker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

"(C) LIMITATION ON LIABILITY BASED ON APPOINTMENT OF DESIGNATED DECISION-MAKER.—If a plan sponsor or named fiduciary appoints a designated decision-maker in accordance with paragraph (2), the plan sponsor or named fiduciary, or any other person or group of persons (or their employees) associated with the plan sponsor or named fiduciary, shall not be liable under this paragraph. The appointment of a designated decision-maker in accordance with paragraph (2) shall not affect the liability of the appointing plan sponsor or named fiduciary for the failure of the plan sponsor or named fiduciary to comply with any other requirement of this title.

"(D) PREVENTION OF DUPLICATION OF ACTION WITH ACTION UNDER STATE LAW.—No action may be brought under this subsection based upon facts and circumstances if a cause of action under State law is brought based upon substantially the same facts and circumstances.

"(2) DESIGNATED DECISION-MAKER.—

"(A) APPOINTMENT.—

(i) In general.—The plan sponsor or named fiduciary of a group health plan shall, in accordance with this paragraph, designate one or more persons to serve as a designated decision-maker with respect to causes of action described in subparagraphs (A) and (B) of paragraph (1), except that—

(I) with respect to health insurance coverage offered in connection with a group health plan, the health insurance issuer shall be the designated decision-maker unless the plan sponsor and the issuer specifically agree in writing (on a form to be prescribed by the Secretary) to substitute another person as the designated decision-maker; or

(II) with respect to the designation of a person other than a plan sponsor or health insurance issuer, such person shall satisfy the requirements of subparagraph (D)(i).

(ii) PLAN DOCUMENTS.—The designated decision-maker shall be specifically designated as such in the written instruments of the plan (unless otherwise identified as required under section 121(b)(14) of the Bipartisan Patient Protection Act.

(iii) AUTHORITY.—A designated decision-maker appointed pursuant to subparagraph (A) shall have the exclusive authority under the group health plan—

(I) to make determinations with respect to claims under section 102 of the Bipartisan Patient Protection Act (relating to an initial claim for benefits); and

(II) to make final determinations under section 103 of such Act (relating to an internal appeal); or

(iv) APPRAISAL.—A designated decision-maker shall have the exclusive authority under the group health plan—

(I) to determine whether a claim is covered under the group health plan (under section 402(a)) and be identified as such in the written instruments of the plan; and

(II) to satisfy such conditions as the Secretary to substitute another person as the designated decision-maker with respect to causes of action described in subparagraphs (A) and (B) of paragraph (1) shall be assessed against the appropriate designated decision-maker.

(iii) QUALIFICATIONS.—

(I) CERTIFICATION OF ABILITY.—To be appointed as a designated decision-maker under this paragraph, a person shall provide to the plan sponsor a written certification of such person's ability to meet the requirements of clause (ii) relating to financial obligation for liability under this subsection. Such certification shall be provided upon appointment and not less frequently than annually thereafter, or if the designation is pursuant to a multi-year contract, in connection with the renewal of the contract, but in no case less than once every 3 years.

(ii) OTHER REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of clause (i), requirements relating to financial obligation for liability shall include evidence of—

(I) coverage of the person under insurance policies or other arrangements, secured and maintained by the person, to insure the person against losses arising from professional liability claims; and

(ii) minimum capital and surplus levels that are maintained by the person to cover any losses as a result of liability arising from being designated as a designated decision-maker under this paragraph.

(iii) The appropriate amounts of liability insurance shall be determined in consultation with the following entities: the AAAP, the American Academy of Actuaries and shall be maintained throughout the course of the contract in which such person is designated as a designated decision-maker.

(iv) FLEXIBILITY IN ADMINISTRATION.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may provide—

(I) that any person or group of persons may serve in more than one capacity with respect to the plan or coverage (including service as a designated decision-maker, administrator, and named fiduciary); or

(ii) that a designated decision-maker may employ one or more full-time medical reviewers with respect to any responsibility of such decision-maker under the plan or coverage.

"(D) QUALIFICATIONS.—

(i) General.—In general, with respect to any cause of action under paragraph (1) relating to a denial of a claim for benefits where a designated decision-maker has not been appointed in accordance with this paragraph, the plan sponsor or named fiduciary responsible for the plan shall be deemed to be the designated decision-maker.

(ii) LIMITATION ON APPOINTMENT.—A treating health care professional who directly delivered the care, treatment, or provided the patient service that is the subject of an action under this subsection may not be designated as a designated decision-maker under this paragraph unless the professional—

(I) is a participant or beneficiary (or the estate) of such participant or beneficiary; and

(ii) specifically agrees to accept such appointment in accordance with the requirements under such subsection.

"(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

(A) IN GENERAL.—Paragraph (1) shall apply only if a final determination denying a claim for benefits under section 102 of the Bipartisan Patient Protection Act has been referred to an independent medical reviewer under section 104(d) of such Act and a written determination of independent medical reviewer has been issued with respect to such review or where the coverage for the benefit involved is approved after the denial is referred to the independent medical reviewer but prior to the determination of the reviewer under this section.

(B) EXCEPTION TO EXHAUSTION FOR NEEDED CARE.—A participant or beneficiary may seek relief under subsection (a)(1)(B) prior to the exhaustion of administrative remedies under section 102 or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Any determinations that are made pursuant to section 102 or 103 of such Act in such case, or that are made in such case while an action under this subsection is pending, shall be given due consideration by the court in any action under this subsection in such case.
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(A) Maximum Award of Noneconomic Damages.—Notwithstanding any other provision of law, in the case of any action commenced pursuant to paragraph (1), the total amount of damages received by a participant or beneficiary under such action shall be reduced, in accordance with clause (ii), by any payment that has been, or will be, made to such participant or beneficiary, pursuant to an order or judgment of another court, to compensate such participant or beneficiary for the injury that was the subject of such action.

(ii) Amount of Reduction.—The amount by which an award of damages to a participant or beneficiary for an injury shall be reduced under clause (i) shall be—

(i) the total amount of any payments (other than such award) that have been made or that are to be made to such participant or beneficiary to pay costs of or compensate such participant or beneficiary for the injury that was the subject of the action; less

(ii) any payment received by such participant or beneficiary (or by the spouse, parent, or legal guardian of such participant or beneficiary) to secure the payments described in subclause (i).

(iii) Determination of Amounts from Collateral Sources.—The reduction required under clause (ii) shall be determined by the court in a prudential proceeding. At the subsequent trial no evidence shall be admitted as to the amount of any charge, payments, or damage for which a participant or beneficiary

(i) has received payment from a collateral source or the obligation for which has been assured by a third party; or

(ii) is, or with reasonable certainty, will be eligible to receive from a collateral source which will, with reasonable certainty, be assumed by a third party.

(iv) Paying Party Award of Punitive Damages.—Notwithstanding any other provision of law, in the case of any action commenced pursuant to paragraph (1), the court may, in its final determination under this section, award punitive damages.

(v) Affirmative Defenses.—In the case of any action under paragraph (1), it shall be an affirmative defense that—

(A) the designated decision-maker of a group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, involved in such plan or issuer did not receive from the participant or beneficiary (or authorized representative) or the treating health care professional (if any), the information requested by the plan or issuer concerning payment of benefits; and

(B) a punitive, exemplary, or similar damages shall be reduced, in accordance with clause (i), by an amount equal to 3 times the total amount of any payments (other than such award) that have been made or that are to be made to such participant or beneficiary for the injury that was the subject of such action, or a period of time elapsed after coverage has been authorized.

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

(6) Waiver of Internal Review.—In the case of any cause of action under paragraph (1), the waiver of internal review under section 103(a)(4) of the Bipartisan Patient Protection Act by the group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, shall not be used in determining liability.

(7) Limitations on Actions.—Paragraph (1) shall not apply in connection with any action that is commenced more than 3 years after the date on which the failure described in paragraph (1) occurred.

(8) Protection of the Regulation of Quality of Health Care Under State Law.—Nothing in this subsection shall be construed to preclude any action under State law against a participant or beneficiary for the failure of a group health plan or health insurance issuer to provide medical care under any State law for purposes of this section. Any such claim shall be maintained exclusively under section 502.

(9) Construction.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage.

(10) Definitions.—In this subsection:

(A) Authorized Representative.—The term ‘authorized representative’ has the meaning given such term in section 102(e)(1) of the Bipartisan Patient Protection Act.

(B) Claim for Benefits.—Except as provided in paragraph (8), the term ‘claim for benefits’ shall have the meaning given such term in section 102(e)(1) of the Bipartisan Patient Protection Act. No claim for benefits consisting of medical care, derivative action, or as an action on behalf of any group of 2 or more claimants,
may be maintained only if the class, the derivative of such decision or cause is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms ‘group health plan’ and ‘health insurance coverage’ have the meanings given such terms in section 733.''.

"(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after the date of enactment of the Bipartisan Patient Protection Act. This subsection shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to such date of enactment.''.

(2) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation of the subsection;

(2) by adding at the end the following:

"(2) No action may be brought under this subsection, or alleging any violation of section 1962, where the action seeks relief concerning, established, administered, or otherwise operated a group health plan, or such insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms ‘group health plan’ and ‘health insurance issuer’ shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.''

(B) Paragraph (A) shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act and all actions commenced on or after such date.

(d) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or'' and the following:

"(B) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of attorneys’ fees awarded under subparagraph (A) as equity and the interests of justice may require.''

SA 833. Mr. WARNER proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 154, between lines 2 and 3, insert the following:

"(11) LIMITATION ON AWARD OF ATTORNEYS’ FEES.—

(A) IN GENERAL.—Subject to subparagraph (C), with respect to a participant or beneficiary who brings a cause of action under this subsection and prevails in that action, the amount of attorneys’ fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved under section 502(k)) may not exceed the sum of the amounts described in subparagraph (B)."

(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 1/5 of the amount of the recovery.

(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $100,000.

(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of attorneys’ fees required under subparagraph (A) as equity and the interests of justice may require.''

Mr. WARNER proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 170, between lines 21 and 22, insert the following:

"(9) LIMITATION ON ATTORNEYS’ FEES.—

(A) IN GENERAL.—Notwithstanding any other provision of this subsection, the amount of an attorney’s fees that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under paragraph (1) to the amount of attorneys’ fees awarded under subparagraph (A) as equity and the interests of justice may require.''

SA 834. Ms. SNOEWE (for herself, Mrs. LINCOLN, Mr. DEWINE, Mr. NELSON of Nebraska, Mr. SPECTER, Mr. MCCAIN, Mr. BAUCUS, Ms. STABENOW, and Mr. CHAFEE) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 106, between lines 16 and 17, insert the following:

"(19) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each designated decisionmaker for purposes of paragraph (A) with respect to participants and beneficiaries of an employer or plan sponsor—

(i) all liability of such employer or plan sponsor to a participant or beneficiary under the plan or coverage involved relates to an item or service that has already been fully provided to the participant or beneficiary under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker;

(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or plan sponsor (or employee thereof acting within the scope of employment or agency under this subsection) in any action or proceeding brought by or on behalf of the participant or beneficiary, including the reimbursement of actual out-of-pocket expenses of an attorney as approved under section 502(k)."

SA 835. On page 106, between lines 16 and 17, insert the following:

"(18) PREVIOUSLY PROVIDED SERVICES.—

(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit a cause of action under paragraph (1) where the denial involved relates to an item or service that has not yet been provided to the participant or beneficiary under the plan or coverage involved; or

(ii) prohibit a cause of action under paragraph (1) where the denial involved relates to an item or service that is not available to the participant or beneficiary under the plan or coverage involved because the participant or beneficiary is subject to a co-payment, co-insurance, or deductible for such item or service.
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“(ii) prohibit a cause of action under para-

graph (1) relating to quality of care; or

“(iii) limit liability that otherwise would

arise from the provision of the item or serv-

ices or the performance of a medical proce-

dure.

“(19) EXEMPTION FROM PERSONAL LIABILITY

FOR INDIVIDUAL MEMBERS OF BOARDS OF DIREC-

tORS, JOINT BOARDS OF TRUSTEES, ETC.—Any

individual who—

“(A) a member of a board of directors of an

employer or plan sponsor; or

“(B) a member of an association, com-

mittee of trustees, or other similar group of re-

presentatives of the entities that are the plan

sponsor of plan maintained by two or more em-

ployers and one or more employee organi-

zations;

shall not be personally liable under this sub-

section for conduct that is within the scope

of employment of the individuals unless the

individual acts in a fraudulent manner for

personal enrichment.

“(20) REQUIREMENTS FOR DESIGNATED DECI-

SIONMAKERS.—

“(1) IN GENERAL.—For purposes of sub-

section (n)(17) and section 514(d)(9), a de-

signated decisionmaker meets the require-

ments of paragraph (3) with respect to any

participant or beneficiary if—

“(A) such designation is in such form as

may be prescribed in regulations of the Sec-

retary.

“(B) the designated decisionmaker—

“(i) meets the requirements of paragraph

(2)(B),

“(ii) assumes unconditionally all liability

of the employer or plan sponsor involved

and (any employee thereof acting within the

scope of employment) either arising under

subsection (n) or arising in a cause of action

permitted under section 514(d) in connection

with actions (and failures to act) of the

employer or plan sponsor (or employee) occur-

ring during the period in which the designa-

tion under subsection (n)(17) or section

514(d)(9) is in effect relating to such partici-

pant or beneficiary.

“(iii) agrees to be substituted for the em-

ployer or plan sponsor (or employee) in the

action and not to raise any defense with re-

spect to such liability that the employer or

plan sponsor (or employee) may not raise, and

“(iv) where paragraph (2)(B) applies, as-

sumes unconditionally liability under sub-

section (n) or arising in a cause of action

permitted under section 514(d) in connection

with actions (and failures to act) of the

employer or plan sponsor (or employee) occur-

ring during the period in which the designa-

tion under subsection (n)(17) or section

514(d)(9) is in effect relating to such partici-

pant or beneficiary.

“(C) the designated decisionmaker and the

participants and beneficiaries for whom the
designation has assumed liability are iden-
tified in the written instrument required under

section 420(a) and as required under section

121(b)(19) of the Bipartisan Patient Protec-

tion Act.

Any liability assumed by a designated deci-

sionmaker under this subsection shall be in-

 addition to any liability that it may oth-

erwise have under applicable law.

“(2) QUALIFICATIONS FOR DESIGNATED DECI-

SIONMAKERS.—

“(A) IN GENERAL.—Subject to subparagraph

(B), an entity is qualified under this para-

graph to serve as a designated decision-

maker under this subsection with respect to

the plan sponsor and the Secretary certification

of such ability. Such certification shall be pro-

vided to the plan sponsor or named fidu-

ciary and to the Secretary upon designation

under subsection (n)(17)(B) or section

514(d)(9)(B) and not less frequently than an-

nually thereafter, or if such designation con-

stitutes a multiyear arrangement, in con-

junction with the renewal of the arrange-

ment.

“(B) SPECIAL QUALIFICATION IN THE CASE OF

CERTAIN REVIEWABLE DECISIONS.—In the case

of a group health plan that provides benefits

to a participant or beneficiary only through

health insurance coverage offered by a single

health insurance issuer, such issuer is the only

entity that may qualify under this paragraph
to serve as a designated decisionmaker with

respect to such participant or beneficiary, and

shall serve as the designated decisionmaker

unless the plan sponsor or plan sponsor acts

affirmatively to prevent such service.

“(3) REQUIREMENTS RELATING TO FINANCIAL

OBLIGATIONS.—For purposes of paragraph

(2)(A), the plan sponsor or plan sponsor (or

employee) may not raise, and

“(A) coverage of such entity under an in-

surance policy or other arrangement, sec-

ured and maintained by such entity, to ef-

fectively insure such entity against losses

arising from professional liability claims, in-

cluding those arising from its service as a

designated decisionmaker under this part; or

“(B) evidence of minimum capital and sur-

plus levels that are maintained by such enti-

ty to comply with any result of liability

arising from its service as a designated deci-

sionmaker under this part.

The appropriate amounts of liability insur-

ance and minimum capital and surplus levels

for purposes under this paragraph (A) and (B)

shall be determined by an actuary using sound

actuarial principles and accounting prac-

tices pursuant to established guidelines of the

American Academy of Actuaries and in ac-

cordance with such regulations as the

Secretary may prescribe and shall be main-

tained throughout the term for which the

designation is in effect.

“(4) LIMITATION ON APPOINTMENT OF TREAT-

ING PHYSICIANS.—A treating physician who

directly delivered the care, treatment, or

services described in subparagraph (A)(i) or (B)

shall be deemed to have assumed uncondi-

tionally all liability of the employer or plan

sponsor involved insofar as such cause of action

provides for personal enrichment.

“(10) PREVIOUSLY PROVIDED SERVICES.—

“(A) IN GENERAL.—Except as provided in

this paragraph, a cause of action shall not

arise under paragraph (1) where the denial

involved relates to an item or service that

has already been fully provided to the partici-

pant or beneficiary under the plan or cov-

erage and the claim relates solely to the sub-

sequent denial of payment for the provision

of such item or service.

“(B) EXCEPTION.—Nothing in subparagraph

(A) shall be construed to prohibit a cause of

action under paragraph (1) where the nonpayment

results in the participant or beneficiary being

unable to receive further items or services

that are directly related to the item or serv-

ice involved in the denial referred to in sub-

paragraph (A) or that are part of a con-

tinuing treatment or series of procedures;

“(ii) prohibit a cause of action under para-

graph (1) relating to quality of care; or

“(iii) limit liability that otherwise would

arise from the provision of the item or serv-

ices or the performance of a medical proce-

dure.

“(11) EXEMPTION FROM PERSONAL LIABILITY

FOR INDIVIDUAL MEMBERS OF BOARDS OF DIREC-

tORS, JOINT BOARDS OF TRUSTEES, ETC.—Any

individual who is—

“(A) a member of a board of directors of an

employer or plan sponsor; or

“(B) a member of an association, com-

mittee, employee organization, joint board of

trustees, or other similar group of re-

presentatives of the entities that are the plan

sponsor of plan maintained by two or more

employers and one or more employee organi-

zations;

shall not be personally liable under this sub-

section for conduct that is within the scope

of employment of the individuals unless the

individual acts in a fraudulent manner for

personal enrichment.
SEC. 136. PRESERVATION OF THE HIPPOCRATIC OATH.

(a) In General.—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 physician (or group of physicians) shall require that such physician—

(1) provide notice to each participant, beneficiary, or enrollee that the physician does not uphold any part of the Oath, disclose the part of the Oath to such participant, beneficiary, or enrollee to which the physician does not subscribe.

(b) Specific Areas of Disclosure.—A physician making a disclosure under subsection (a)(1) shall—

(I) be available to any resident of a State who—

(I) is without access to adequate health insurance through the resident’s employer; or

(II) is from a family with an income that is less than 220 percent of the poverty line, is not eligible for benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), and is not eligible for veteran’s health benefits, and is younger than 65 years of age; and

(ii) be used to provide a benefit for private insurance that includes, at a minimum, catastrophic coverage.

(c) Time Period.—In general.—A State shall have in place a refundable tax credit as described in subsection (a)(1), not later than 2 years after the date of enactment of the Bipartisan Patient Protection Act.

(b) Requirements.—A State that fails to have a refundable tax credit in place as required by clause (I) shall transfer any funds described in subsection (a)(2) to the National Institutes of Health.

SA 836. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 171, between lines 14 and 15, insert the following:

SEC. 306. DEDICATION OF PUNITIVE DAMAGES FOR FAILURES IN PAID-BEFORE-DEATH COVERAGE.

(a) Award of Portion of Damages.—

(1) In general.—If any penalty is assessed, or non-economic or punitive damages are awarded with respect to a cause of action under section 502(a) or 514(d) of the Employee Retirement Income Security Act of 1974 (as added by section 302), the court shall award the amount described in paragraph (2) to the State health insurance trust fund established under subsection (b) for the State in which the claim filed to enable the State to provide refundable tax credits to eligible individuals in the State to purchase health insurance coverage.

(2) Amount.—The amount awarded to a State under paragraph (1) shall consist of—

(A) any non-economic or punitive damages awarded in excess of $2,000,000.

(b) Requirements.—

(1) State Health Insurance Trust Fund.—A State that desires to receive payments under subsection (a) shall establish a State health insurance trust fund.

(2) Refundable Tax Credit.—

(A) In general.—The refundable tax credit described in subsection (a)(1) shall—

(I) be available to any resident of a State who—

(I) is without access to adequate health insurance through the resident’s employer; or

(II) is from a family with an income that is less than 220 percent of the poverty line, is not eligible for benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), and is not eligible for veteran’s health benefits, and is younger than 65 years of age; and

(ii) be used to provide a benefit for private insurance that includes, at a minimum, catastrophic coverage.

(b) Time Period.—

(1) In general.—A State shall have in place a refundable tax credit as described in subsection (a)(1), not later than 2 years after the date of enactment of the Bipartisan Patient Protection Act.

(b) Requirements.—A State that fails to have a refundable tax credit in place as required by clause (I) shall transfer any funds described in subsection (a)(2) to the National Institutes of Health.
SA 838, Mrs. HITCHISON submitted an amendment intended to be opposed by her to the bill S. 1052, to amend the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage which was ordered to lie on the table; as follows:

Beginning on page 98, strike line 2 and all that follows through line 21 on page 109, and insert the following:

SEC. 121. PATIENT ACCESS TO INFORMATION.

(8) Access of the Participant, Beneficiary, or Enrollee.—

(1) of such information on an annual basis—

(A) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

(B) if the plan or coverage does not have such an election period, in conjunction with the beginning of the plan or coverage year;

(ii) of information relating to any material reduction to the benefits or information described in paragraph (1), (2), or (3) of subsection (b), in the form of a notice provided not later than the date on which the reduction takes effect; and

(iv) of the additional information described in subsection (c).

(b) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under subparagraph (a) shall include—

(i) jointly to each participant, beneficiary, and enrollee who resides at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant, to the extent that such information is provided to participants, beneficiaries, or enrollees, to the extent of the participant, beneficiary, or enrollee.

(c) EXCEPTIONS.—The requirements of this section shall not apply—

(1) to employees or former employees of a covered employer; or

(2) with respect to certain periods of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;
9. EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard (as described in section 113(c)) applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

10. CLAIMS AND APPEALS.—A description of the plan or issuer’s rules and procedures pertaining to claims and appeals, a description of the deadlines for exercising rights (including an explanation of the consequences of exercising rights) of participants, beneficiaries, and enrollees under subtitle A in obtaining covered benefits, filing a claim for benefits, and appealing denials of claims and payment of medical bill notices, and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

11. ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions that the plan or issuer maintains.

12. INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage are provided under a contract or policy of insurance or an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

13. TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants, beneficiaries, and enrollees with communication disabilities and a description of how to access these items or services.

14. ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations as a result of the accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants, beneficiaries, and enrollees.

15. NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (including those described in paragraphs (1) through (14)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary may determine to be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

16. ADMINISTRATION OF HEALTH CARE ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 131 and 132, including any drug formulary program under section 118.

17. EXTERNAL APPEALS INFORMATION.—A description on the number and outcomes of external medical reviews, relative to the sample size (such as the number of covered lives) under the plan or under the coverage, if applicable.

18. RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; and

(2) complying with the provisions of this section by providing information in brochures, through the Internet or other electronic media, or through other similar means, so long as—

(A) the disclosure of such information in such form is in accordance with requirements as the appropriate Secretary may impose, and

(B) in connection with any such disclosure of information through the Internet or other electronic media—

(i) the recipient has affirmatively consented to the disclosure of such information in such form, (ii) the recipient is capable of accessing the information so disclosed on the recipient’s individual workstation or at the recipient’s home, (iii) the recipient retains an ongoing right to receive paper disclosure of such information, and (iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

SA 839. Mrs. HUTCHISON (for herself and Mrs. CLINTON) submitted an amendment intended to be proposed by her to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 101, between lines 14 and 15, insert the following:

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

SA 840. Mr. ENZI proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 172, between lines 15 and 16, insert the following:

SC. 304. IMMUNITY FROM LIABILITY FOR PROVIDING INSURANCE OPTIONS.—

(a) In general.—Nothing in subsection (b) with respect to a participant or beneficiary against a group health plan described in paragraph (b) if such plan offers the participant or beneficiary the coverage option described in paragraph (b).

(b) Coverage option.—The coverage option described in this paragraph is one under which the group health plan, at the time of enrollment or as provided for in paragraph (c), provides the participant or beneficiary with the option to—

(A) enroll for coverage under a fully insured health plan;

(B) receive an individual benefit payment, in an amount equal to the amount that would be contributed on behalf of the participant or beneficiary by the plan sponsor for enrollment in the group health plan (as determined by the plan actuary, including factors relating to participant or beneficiary’s age and health status), for use by the participant or beneficiary in obtaining health insurance coverage in the individual market.

(c) Time of offering of option.—The coverage option described in this paragraph shall be offered to a participant or beneficiary—

(A) during the first period in which the individual is eligible to enroll under the group health plan; or

(B) during any special enrollment period provided by the group health plan after the date of enactment of the Patients’ Bill of Rights Plus Act for purposes of offering such coverage option.

(d) Exclusion from income.—Section 106 of the Internal Revenue Code of 1986 relating to contributions by employer to accident and health plans is amended by adding at the end the following:

"(6) TREATMENT OF CERTAIN COVERAGE OPTIONS UNDER SELF-INSURED PLANS.—No amount shall be included in the gross income of an individual by reason of—

(A) the individual’s election to elect a coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, or

(B) the receipt by the individual of an individual benefit payment described in section 502(o)(2)(A) of such Act."
At the end, add the following:

SEC. 9511. HEALTH INSURANCE REFUNDABLE CREDITS TRUST FUND.

(a) Creation of Trust Fund.—There is hereby established in the Treasury of the United States a trust fund to be known as the 'Health Insurance Refundable Credits Trust Fund', consisting of such amounts as are appropriated to such Trust Fund as provided in this section, or credited to such Trust Fund as provided in section 9602(b).

(b) Transfer to Trust Fund of Amounts Equivalent to Certain Awards.—There are hereby appropriated to the Health Insurance Refundable Credits Trust Fund amounts equivalent to the awards received by the Secretary of the Treasury under section 733 of the Employee Retirement Income Security Act of 1974.

(c) Expenditures From Trust Fund.—Amounts in the Health Insurance Refundable Credits Trust Fund shall be available to fund the appropriations under paragraph (2) of section 1324(b) of title 31, United States Code.

(d) Discretionary Tax Credit.—The Secretary of the Treasury may use any refundable tax credit to assist uninsured individuals and families with the purchase of health insurance under this title."

SEC. 9512. EXPENDITURES FROM TRUST FUND.

(1) In General.—No private action may be brought under this subsection, or alleging any violation of section 6080, or otherwise operated a group health plan, or health insurance issuer offering group health insurance coverage issued in connection with a group health plan, as a class, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative action claimant, or group of claimants, is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding.

(b) Effective Date.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.

(c) Limitation on Class Action Litigation.—There are hereby appropriated to the Health Insurance Refundable Credits Trust Fund amounts equivalent to the awards received by the Secretary of the Treasury under section 733 of the Employee Retirement Income Security Act of 1974.

(d) Limitation on Class Action Litigation.—There are hereby appropriated to the Health Insurance Refundable Credits Trust Fund amounts equivalent to the awards received by the Secretary of the Treasury under section 733 of the Employee Retirement Income Security Act of 1974, and all actions that are filed not earlier than that date.

SEC. 843. MR. GRAMM (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 156, strike lines 15 and 16 and insert the following:

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(1) limitation on class action litigation.

(A) In General.—Any claim or cause of action that is maintained under section (1) of title 29, public health service act, and all actions that are filed not earlier than that date.

(B) Definitions.—In this paragraph, the term 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

(2) Effective Date.—Paragraph (1) shall apply to all actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.

(3) Racketeer Influenced and Corrupt Organizations Act.—Section 1962(c) of title 18, United States Code (A) by inserting "(1)" after the subsection designation; and
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(B) by adding at the end the following:

“(2) Nothing contained under subsection (a) of this section shall be construed to prevent the establishment of a medical research program, including clinical trials, which is intended to develop new treatments for serious or life-threatening diseases.

(3) Nothing in this section shall be construed to prevent the performance of any research activity that is conducted for the purpose of developing new treatments for serious or life-threatening diseases.

SEC. 03. PROHIBITION ON HUMAN GERMLINE GENE MODIFICATION

(a) IN GENERAL.—(1) It shall be unlawful for any person or entity, public or private, to import the product of human germline gene modification for any purpose.

(2) No action may be brought under this section to enjoin any person or entity, public or private, to perform human germline gene modification for any purpose.

(b) PENALTIES.—(1) In general.—Any person or entity that is convicted of violating any provision of this section shall be subject to, in addition to any other penalty that may be imposed, a civil penalty of not less than $1,000,000 and not more than an amount equal to the amount of the gross gain multiplied by 2, if that amount is greater than $1,000,000.

(2) CRIMINAL PENALTIES.—In any case of willful violation of any provision of this section, any person or entity that is convicted of violating any provision of this section shall be fined under this section and imprisoned for not more than 10 years, or both.

SEC. 04. APPLICABILITY OF OTHER LAWS

Nothing in this Act shall be construed to impair the authority of the Federal Communications Commission to regulate the use of electromagnetic energy for medical research purposes.

SEC. 05. SEVERABILITY

If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of this Act, and the application of such provision to other persons or circumstances, shall not be affected thereby.

SEC. 06. IMPLEMENTATION

The President shall, by the end of the 120th day following the date of the enactment of this Act, issue such regulations as may be necessary to implement this Act.

SEC. 07. CONFORMING AMENDMENT

The amendment made by section 2 of this Act shall be construed to conform to section 301 of the Employee Retirement Income Security Act of 1974, as amended by this Act.

SEC. 08. TECHNICAL CORRECTION

The amendment made by section 2 of this Act shall be construed to conform to section 151 of the Employee Retirement Income Security Act of 1974, as amended by this Act.

SEC. 09. Removal of removed references

The amendment made by section 2 of this Act shall be construed to remove any reference thereto.

SEC. 10. Authorization of appropriations

There are authorized to be appropriated to carry out this Act such sums as may be necessary.

SEC. 11. EFFECTIVE DATE

This Act shall take effect 180 days after the date of the enactment of this Act.

SEC. 12. Repeal

Section 302 of the Employee Retirement Income Security Act of 1974 is repealed.

SEC. 13. Approximation

Nothing in this Act shall be construed to diminish the rights of any person or entity under any other law.

SEC. 14. Compliance

Nothing in this Act shall be construed to require any person or entity to comply with any regulation or requirement that is inconsistent with the requirements of this Act.

SEC. 15. Repeal and Reenactment

The amendment made by section 2 of this Act is hereby repealed and the amendment made by section 1 of the Genetic Information Nondiscrimination Act of 2008 is hereby reenacted.
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genes, gene products, or inherited characteristics from an individual or a family member of such individual (including information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(3) The term "predictive genetic services" means health services, including genetic tests, provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(4) The term "genetic information" shall not include—

(i) information about the sex or age of the individual;

(ii) information about chemical, blood, or urine analyses of the individual, unless these analyses are genetic tests;

(iii) information about physical exams of the individual, and other information relevant to determining the current health status of the individual;

(b) LIMITATIONS.—The term "predictive genetic information" shall not include—

(i) information about the sex or age of the individual;

(ii) information about chemical, blood, or urine analyses of the individual, unless these analyses are genetic tests;

(iii) information about physical exams of the individual, and other information relevant to determining the current health status of the individual;

(4) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—The term "collection of predictive genetic information" has been provided in subsections (c) and (d), a group health plan, or a health insurance issuer offering health insurance coverage, shall not request, require, collect, or purchase predictive genetic information or provide for the payment of a claim.

(b) LIMITATIONS.—Nothing in this section shall be construed to limit or restrict the disclosure of predictive genetic information from a health care provider to another health care provider for the purpose of providing health care treatment to the individual involved.

(c) VIOLATION OF GENETIC DISCRIMINATION OR GENETIC DISCLOSURE PROVISIONS.—

(1) In general.—In any action under a covered provision against any administrator of a health plan or issuer offering health insurance coverage (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney’s fees and costs, including the costs of expert witnesses.

(2) DEFINITION.—In this subsection, the term "covered provision" means section 502 of Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) or section 2722 or 2761 of the Public Health Service Act (42 U.S.C. 300gg–2, 300gg–41).

(a) No enrollment restriction for genetic services.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not establish rules for enrollment, eligibility (including continued eligibility) of the plan based on genetic information (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) to—

(i) any entity that is a member of the same controlled group as such issuer or plan sponsor of such group health plan;

(ii) any other group health plan or health insurance issuer or any insurance agent, third party administrator, or other person (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney’s fees and costs, including the costs of expert witnesses.

(b) No discrimination in group rate based on predictive genetic information.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not deny eligibility to a group or adjust premium or contribution rates for a group on the basis of predictive genetic information concerning an individual in the group (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(c) Limitation on genetic testing.—

(A) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A group health plan, or a health insurance issuer offering health insurance coverage, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) LIMITATION ON GENETIC TESTING.—Nothing in this section shall be construed to limit the authority of a health care professional, who is providing treatment with respect to an individual or family member of such individual undergoing a genetic test, to request that such individual or family member of such individual undergo a genetic test.

(2) Collection of predictive genetic information.—The provisions of paragraphs (4) (regarding collection) and (5) of subsection (b) shall not apply to an individual if the information concerning an individual (or legal representative of the individual) provides prior, knowing, voluntary, and written authorization for the collection or disclosure of predictive genetic information.

(2) Disclosure for health care treatment.—Nothing in this section shall be construed to limit or restrict the disclosure of predictive genetic information from a health care provider to another health care provider for the purpose of providing health care treatment to the individual involved.

(3) Violation of genetic discrimination or genetic disclosure provisions.—

(a) In general.—In any action under a covered provision against any administrator of a health plan or issuer offering health insurance coverage (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney’s fees and costs, including the costs of expert witnesses.

(b) Definitions.—In this subsection, the term "covered provision" means section 502 of Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) or section 2722 or 2761 of the Public Health Service Act (42 U.S.C. 300gg–2, 300gg–41).

Section 2721(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–20) is amended in subparagraph (A), by striking "If the plan sponsor" and inserting "Except as provided in subparagraph (D), if the plan sponsor"; and

(2) adding at the end the following:

"(D) Election not applicable to requirements concerning genetic information.—

The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (b), (c), and (d) of section 122 of the Bipartisan Patient Protection Act and the provisions of section 2722(b)(2)(D) of the Public Health Service Act concerning the collection or disclosure of genetic information (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) to—

(i) any entity that is a member of the same controlled group as such issuer or plan sponsor of such group health plan;

(ii) any other group health plan or health insurance issuer or any insurance agent, third party administrator, or other person (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney’s fees and costs, including the costs of expert witnesses.

(b) Special rule in case of genetic information.—With respect to health insurance coverage offered by a health insurance issuer, the provisions of this section relating to genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) shall not be construed to supersede any provision of State law that establishes, implements, or continues in effect a standard, requirement, or penalty that more completely—

(1) protects the confidentiality of genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) to—

(i) any entity that is a member of the same controlled group as such issuer or plan sponsor of such group health plan;

(ii) any other group health plan or health insurance issuer or any insurance agent, third party administrator, or other person (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney’s fees and costs, including the costs of expert witnesses.

Section 203. Elimination of option of non-federal governmental plans to be excepted from requirements concerning genetic information.
SEC. 204. APPLICATION OF GENETIC NON-DISCRIMINATION REQUIREMENTS TO MEDIGAP PLANS.

(a) NONDISCRIMINATION.—Section 1882(a)(2) of the Social Security Act (42 U.S.C. 1395ss(a)(2)) is amended by adding at the end the following:

"(E) Each issuer of a Medicare supplemental policy, and each such policy offered by such issuer, shall comply with the requirements under section 122 of the Bipartisan Patient Protection Act.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to each issuer of a Medicare supplemental policy and each such policy for policy years beginning after October 1, 2002.

(c) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendment made by subsection (a), such State regulatory program shall not be considered to be out of compliance with the requirements under section 122 of the Social Security Act (42 U.S.C. 1395ss) due solely to failure to make such change until the date specified in paragraph (4).

(2) SPECIFIED DATES.—If, not later than June 30, 2002, the National Association of Insurance Commissioners (in this subsection referred to as the "NAIC") modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendment made by subsection (a), such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC Model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall, not later than October 1, 2002, make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) October 1, 2002.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendment made by subsection (a); but

(ii) having legislation which is not scheduled to meet in 2002 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 2002. For purposes of the previous sentence, in the case of a State that has a legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 205. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) In General.—Section 301(a) of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsection C as subsection D; and

(2) by inserting after subsection B the following:

"SUBCHAPTER C—PATIENT PROTECTION STANDARDS"

"SEC. 9821. PATIENT PROTECTION STANDARDS.

"(a) In general.—Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act, 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 section.

(b) APPLICATION TO EMPLOYERS WITH FEWER THAN 2 EMPLOYEES.—Section 7702A of the Internal Revenue Code of 1986 (26 U.S.C. 1395ss(a)) is amended by striking "this chapter" and inserting "this chapter (other than section 9821)," and inserting "sections 711 and 714(a) (with respect to the application of section 122 of the Bipartisan Patient Protection Act)."

SEC. 301A. APPLICATION TO EMPLOYERS WITH FEWER THAN 2 EMPLOYEES.

Section 7702A of the Internal Revenue Code of 1979 (26 U.S.C. 1395ss(a)) is amended by striking "this chapter" and inserting "this chapter (other than section 7702A)," and inserting "sections 711 and 714(a) (with respect to the application of section 122 of the Bipartisan Patient Protection Act)."

SEC. 122. MODIFICATION OF NAIC MODEL REGULATION.

(1) AUTHORITY FOR COMMITTEES TO MEET

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in paragraph (1) for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) October 1, 2002.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendment made by subsection (a); but

(ii) having legislation which is not scheduled to meet in 2002 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 2002. For purposes of the previous sentence, in the case of a State that has a legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.