CONGRESSIONAL RECORD—SENATE

July 9, 2001

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on National Parks of the Committee on Energy and Natural Resources.

The hearing will take place on Thursday, July 26, 2001, beginning at 2:30 p.m. in room 366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of the hearing is to receive testimony on the following bills:

- S. 817, to amend the National Trails System Act to designate the Old Spanish Trail as a National Historic Trail;
- S. 941, to revise the boundaries of the Golden Gate National Recreation Area in the State of California, to extend the term of the advisory commission for the recreation area, and for other purposes;
- S. 1057, to authorize the addition of lands to Pūhōhō o Hōnaunau National Historical Park in the State of Hawaii, and for other purposes;
- S. 1105, to provide for the expedited completion of the acquisition of State of Wyoming lands within the boundaries of Grand Teton National Park, and for other purposes; and
- H.R. 640, to adjust the boundaries of Santa Monica Mountains National Recreation Area, and for other purposes.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Subcommittee on National Parks. For further information, please contact Linda J. Gustitus of the subcommittee staff at (202) 242-3721.

BIPARTISAN PATIENT PROTECTION ACT

On June 29, 2001, the Senate passed S. 1052, as follows:

S. 1052

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 Patient Protection Act".

(b) Table of Contents.—The table of contents of this Act is as follows:

† Preliminary.
† Title I—Improving Managed Care
† Subtitle A—Utilization Review; Claims; and Internal and External Appeals
† Sec. 101. Utilization review activities.
† 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.
† Sec. 203. Cooperation between Federal and State authorities.
† Sec. 204. Elimination of option of non-Federal governmental plans to be excepted from requirements concerning genetic information.

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

Sec. 1. Short title; table of contents.
Sec. 604. Sense of Senate with respect to

Sec. 603. Fiscal year 2002 medicare pay-

Sec. 602. Customs user fees.

Sec. 601. No impact on Social Security Trust

Sec. 503. Severability.

written policies and procedures that govern

coverage only in accordance with a utiliza-

health care services, procedures or settings,

meaning procedures used to monitor or evaluate

reimbursement or prospective review.

Sec. 404. Limitations on actions.

Sec. 403. Limitation on certain class action

Sec. 402. Availability of civil remedies.

Sec. 401. Effect of class action litigation.

Sec. 400. Cooperation between Federal and

Sec. 399. Sense of the Senate concerning the

importance of certain unpaid services.

TITLE IV—IMMEDIATELY AVAILABLE FUNDS

Sec. 301. Title IV.

Sec. 300. Sense of the Senate with respect to

in Title II of the Social Security Act.

Sec. 300A. Sense of the Senate with respect to

the Social Security Act.

Sec. 300B. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 300C. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 300D. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 300E. Sense of the Senate with respect to

the Railroad Retirement Act.

Sec. 300F. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 300G. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 300H. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 300I. Sense of the Senate with respect to

the Railroad Retirement Act.

Title V—IMMEDIATELY AVAILABLE FUNDS

Sec. 501. Title V.

Sec. 500. Sense of the Senate with respect to

the Social Security Act.

Sec. 500A. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 500B. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500C. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 500D. Sense of the Senate with respect to

the Railroad Retirement Act.

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the Employee Retirement Income Security Act of

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the Railroad Retirement Act.

Sec. 500I. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 500J. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500K. Sense of the Senate with respect to

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Sec. 500L. Sense of the Senate with respect to

the Railroad Retirement Act.

Sec. 500M. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 500N. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500O. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 500P. Sense of the Senate with respect to

the Railroad Retirement Act.

Sec. 500Q. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 500R. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500S. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 500T. Sense of the Senate with respect to

the Railroad Retirement Act.

Sec. 500U. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 500V. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500W. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 500X. Sense of the Senate with respect to

the Railroad Retirement Act.

Sec. 500Y. Sense of the Senate with respect to

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1974.

Sec. 500Z. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500AA. Sense of the Senate with respect to

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Sec. 500AB. Sense of the Senate with respect to

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1974.

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1974.

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1974.

Sec. 500AP. Sense of the Senate with respect to

the Internal Revenue Code.

Sec. 500AQ. Sense of the Senate with respect to

the Medicare扩医疗保险扩 Act.

Sec. 500AR. Sense of the Senate with respect to

the Railroad Retirement Act.

Sec. 500AS. Sense of the Senate with respect to

the Employee Retirement Income Security Act of

1974.

Sec. 500AT. Sense of the Senate with respect to

the Internal Revenue Code.
jeopardize the life or health of the partici-

tant, beneficiary, or enrollee or, in the case of

the participant, beneficiary, or enrollee to

maintain or regain maximum function. Such
determination shall be made in accordance

with the medical exigencies of the case and

as soon as possible, but in no case later than
72 hours after the time the request is re-
ceived by the plan or issuer under this sub-
paragraph.

(C) ONGOING CARE.—

(1) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the

case of a concurrent review of ongoing care
(including hospitalization), which re-

sults in a termination or reduction of such
care, the plan or issuer must provide by tele-

phone and in printed form notice of the con-
current review determination to the indi-

vidual or the individual’s designee and the

individual’s health care provider in accord-

ance with the medical exigencies of the case
and as soon as possible, with sufficient time
prior to the termination or reduction for the

participant, beneficiary, or enrollee to com-

ply with the requirements of this section.

(ii) RULE OF CONSTRUCTION.—Clause (i)

shall not be construed as requiring plans or

issuers to provide coverage of care that

would exceed the coverage limitations for

such care.

(2) RETROSPECTIVE DETERMINATION.—A

group health plan, or health insurance issuer

offering health insurance coverage, shall

make a retrospective determination on a

claim for benefits in accordance with the

medical exigencies of the case and as soon as
possible, but not later than 30 days after the
date on which the plan or issuer receives in-
formation that is reasonably necessary to

enable the plan or issuer to make a determi-

nation on the claim, or, if earlier, 60 days
after the date of receipt of the claim for ben-

efits.

(e) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The

term “authorized representative” means,

with respect to an individual who is a partic-

ipant, beneficiary, or enrollee, any health

care professional or other person acting on

behalf of the individual who is necessary to

provide the individual’s consent or without

such consent if the indi-

vidual is medically unable to provide such

consent.

(2) CLAIM FOR BENEFITS.—The term “claim

for benefits” means any request for coverage
(including authorization of coverage), for eli-
gibility, for preadmission or preauthorization for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The
term “denial” means, with respect to a

claim for benefits, a denial (in whole or in

part) of, or a failure to act on a timely basis

upon, the claim for benefits and includes a

failure to provide benefits (including item or

services) required to be provided under the

plan or health insurance coverage, shall expedite a

claim for benefits under section 102 within the ap-

licable timeline established for such a de-

termination under such section is a denial of a

claim for benefits for purposes of this subpart as of the date of the applicable deadline.

(4) PLAN WAIVER OF INTERNAL REVIEW.—

A group health plan, or health insurance issuer

offering health insurance coverage, may waive

the internal review process under this section.

In such case the plan or issuer shall provide

notice to the participant, beneficiary, or enrollee (or authorized representative) in

volvement shall be relieved of any obligation to

complete the internal review involved, and

the issuer, or, in the case described in sub-

paragraph (A), the participant, beneficiary,
or enrollee (or authorized representative) in-

rolled in making a determination and a health care professional certifies, with

the request, that a determination under the

case and as soon as possible, but not later than 14

days from the date on which the plan or issuer

receives information that is reason-

able necessary to enable the plan or issuer to make a determination on the appeal and in

no case later than 28 days after the date the

request for the appeal is received.

(b) EXPEDITED DETERMINATION.—Notwith-

standing subparagraph (A), a group health

plan, or health insurance issuer offering

health insurance coverage, shall expedite a

prior authorization determination on an

appeal of a denial of a claim for benefits

under this subsection in accordance with the

medical exigencies of the case and as soon as
possible, but not later than 72 hours after the
time the request for such appeal is received by the plan or issuer under this subparagraph.
The applicable timeline established for such a determination on an appeal of a denial of a claim for benefits under this section shall be the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination); and (C) notification of the right to an independent external review under section 104 and instructions on how to initiate such a review.

SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a denial of a claim for benefits within 72 hours or applicable period referred to in subsection (b)(3), within 2 days after the date of completion of the review, and in no case later than 60 days after the date the request for the appeal is received.

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

(1) TIME TO FILE.—A request for an independent external review under this section shall be filed with the plan or issuer not later than 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the determination under section 103(d) or notice of waiver of internal review under section 103(a)(4) or the date on which the participant or issuer has failed to make a timely decision under clause (ii) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(2) FILING OF REQUEST.—(A) IN GENERAL.—Written notice of a request for an independent external review under this section shall include the specific reasons for the determination; and (B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(i) ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request may be made orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the health plan. A written confirmation shall be treated as a consent for purposes of subparagraph (A)(iv). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such an external review without regard to the form and manner specified in guidelines established for such request.

(ii) exception TO filing PER REQUiRMENT.—

SEC. 100. REGULATORY EXEMPTIONS.

(a) IN GENERAL.—Written notice of a determination made under an internal appeal of a denial of a claim for benefits under this section shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

(b) Peer REVIEW OF MEDICAL DECISIONS BY HEALTH CARE PROFESSIONALS.—A review of an appeal of a denial of a claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts—

(i) shall be made by a physician (allopathic or osteopathic); or

(ii) in a claim for benefits provided by a non-physician health professional, shall be made by qualified reviewers including at least one practicing non-physician health professional of the same or similar specialty; with appropriate expertise (including, in the case of a child, appropriate pediatric expertise) and who is licensed to practice within the State in which the service is provided or rendered, who was not involved in the initial determination.

(c) Notice OF determination.—

(1) IN GENERAL.—Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of completion of the review (or, in the case described in subparagraph (B) or (C) of subsection (b)(3), within the 72-hour or applicable period referred to in such paragraph).

(2) Final determination.—The decision by a plan or issuer under this section shall be treated as the final determination of the plan or issuer if the denial of a claim for benefits. The failure of a plan or issuer to issue a determination on an appeal of a denial of a claim for benefits under this section within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits for purposes of proceeding to external reviews. The failure of a plan or issuer to issue a determination on a request for an external appeal under section 104 shall be treated as a consent for purposes of subparagraph (A)(iv). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such an external review without regard to the form and manner specified in guidelines established for such request.

(d) Notice OF Determination.—

(1) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review determination described in section 102(b)(1)(C)(i)(I), which results in a termination or reduction of such care, the plan or issuer must provide notice of the determination on the appeal under this section by telephone and in printed form to the individual and the individual’s designated representative or individual’s health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction for the plan or issuer to issue a determination under section 104 to be completed before the termination or reduction takes effect.

(ii) Rule OF Construction.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.
independent medical review if the benefit for denial of a claim for benefits is eligible for timeline and within 2 days of the date of participant, beneficiary, or enrollee (or authorized reviewer, the entity shall provide notice in accordance with subparagraph (C).

B. USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified personnel to make determinations under this section.

C. NOTICES AND GENERAL TIMELINES FOR DETERMINATION.—

(1) NOTICE IN CASE OF DENIAL OF REFERRAL.—If the entity under this paragraph does not make a referral to an independent medical reviewer, the entity shall provide notice to the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) filing the request, and the treating health care professional (if any) that the denial is not subject to independent medical review. Such notice—

(i) shall be written (and, in addition, may be provided orally) in a manner calculated to be understood by a participant or enrollee;

(ii) shall include the reasons for the determination;

(iii) include any relevant terms and conditions of the plan or coverage; and

(iv) include any further recourse available to the individual.

(2) GENERAL TIMELINES FOR DETERMINATIONS.—Upon receipt of information under paragraph (2), the qualified external review entity, and if required the independent medical reviewer, shall make a determination within the overall timeline that is applicable to the case under review as described in subsection (d), except that if the entity determines that a referral to an independent medical reviewer is not required, the entity shall provide notice of such determination to the participant, beneficiary, or enrollee (or authorized representative) within such timeline and within 2 days of the date of such determination.

D. INDEPENDENT MEDICAL REVIEW.—

(1) IN GENERAL.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial to an independent medical reviewer for the conduct of an independent medical review under this subsection.

(2) MEDICALLY REVIEWABLE DECISIONS.—A denial of a claim for benefits is eligible for independent medical review if the denial is of the item or service for which the claim is made would be a covered benefit under the terms and conditions of the plan or coverage but for one (or more) of the following determinations.

A. DENTAL OR MEDICAL Necessity and Appropriateness.—A determination that the item or service is not covered because it is not necessarily and appropriate or based on the application of substantially equivalent terms.

B. DENTAL OR MEDICAL Experimental or Investigational Treatment.—A determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms.

C. DENTAL OR MEDICAL OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

D. INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(1) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to coverage of the item or service or condition.

(ii) EXPEDITED DETERMINATION.—Notwithstanding any other provision of this Act, any exclusion of a health insurance coverage, provide coverage for items or services for which benefits are specifically excluded under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)), notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage documents) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)).

(2) STANDARD FOR DETERMINATION.—The independent medical reviewer’s determination relating to the medical necessity and appropriateness, or the experimental or investigation nature, or the evaluation of the medical facts of the item, service, or condition shall be based on the medical condition of the participant, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.

E. NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require a group health plan or health insurance issuer offering health insurance coverage, that a plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)).

(3) NOTICES OF INDEPENDENT DETERMINATION.—(1) IN GENERAL.—An independent medical reviewer under this section shall, upon making a determination with respect to the application of cost-sharing requirements, provide notice of such determination to the plan, issuer, participant, beneficiary, or enrollee (or an authorized representative) at any time during the process for making a determination, and a health care professional certifies, with the request, that the determination described in clause (1) would seriously jeopardize the life or health of the participant,
beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or participate in any function. Such determination shall be made as soon in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 30 days after the time the request for external review is received by the qualified external review entity.

(III) DETERMINATION OF EXTERNAL REVIEW ENTITY.—Notwithstanding clause (i), in the case of a review described in such subclause that involves a termination or reduction of care, the determination of an independent medical reviewer prepared under subsection (d)(3) and in no case later than 60 days after the date the request for external review is received by the qualified external review entity and before the end of the approved period of care.

(B) RETROSPECTIVE DETERMINATION.—The independent medical reviewer (or reviewers) shall complete a review in the case of a retrospective determination on an appeal of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in no case later than 60 days after the receipt of information under subsection (c)(2) and in no case later than 30 days after the date the request for external review is received by the qualified external review entity.

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if involved) are notified of the determination of an independent medical reviewer provided (regardless of any plan limitations that may apply to the coverage of such items or services) as soon as the items or services were provided in a manner consistent with the determination of the independent medical reviewer.

(C) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant, beneficiary, or enrollee in accordance with this paragraph, the professional, participant, beneficiary, or enrollee may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is owed by the plan or issuer and any necessary legal costs or expenses (including attorney’s fees) incurred in recovering such reimbursement.

(D) AVAILABILITY OF REMEDIES.—The remedies provided under this paragraph are in addition to any other available remedies.

(3) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSAL TO AUTHORIZE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(1) MONETARY PENALTIES.—

(i) IN GENERAL.—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 determination, causes such refusal may, in the discretion of a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount not to exceed the lesser of—

(A) $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.

(B) $500,000.

(ii) ADDITIONAL PENALTY FOR FAILING TO FOLLOW TIMELINE.—In any case in which treatment is authorized by a plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan or issuer for each day the reimbursement is delayed, in violation of this section under such pattern or practice; or

(iii) not otherwise have a conflict of interest, or

(iv) not have a material familial, financial, or professional relationship with such a person.

(B) CEASE AND DESIST ORDER AND ORDER OF INJUNCTION.—In any case where a person is responsible under the terms and conditions of the plan or coverage which such person is responsible under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

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

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

(C) ADDITIONAL CIVIL PENALTIES.—

(i) IN GENERAL.—In addition to any penalty imposed upon a plan or issuer under subparagraph (A) or (B), 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 to be under a plan or issuer of 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 to be under a plan or issuer.

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

(III) STANDARD OF PROOF AND AMOUNT OF PENALTY.—Such penalty shall be payable only upon proof by clear and convincing evidence that such pattern or practice existed 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.

(D) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in subparagraph (A) shall be removed from any such position or involvement for a period determined by the court.

(E) PROHIBITION OF LITIGATING PARTIES.—

(i) IN GENERAL.—There shall not be any party who has engaged in any such pattern or practice who is permitted to file or maintain any action under this section or with respect to such plan or coverage.

(ii) NOT APPLICABLE TO CASES WHERE BENEFIT IS NOT AUTHORIZED.—Such prohibition shall not apply to any case in which a plaintiff alleges that a person referred to in such subparagraph has taken an action or failed to act; and

(iii) not otherwise have a conflict of interest, or

(iv) not have a material familial, financial, or professional relationship with such a party; and

(v) not otherwise have a conflict of interest with such a party (as defined under regulations).

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

(1) prohibit an individual, solely on the basis of affiliation with the plan or issuer,
(C) the health care professional that provides the items or services involved in the denial. (D) the institution at which the items or services (or treatment) involved in the denial are provided.
(E) the manufacturer of any drug or other item that is included in the items or services involved in the denial.
(F) any other person determined under any regulations to have a substantial interest in the denial involved.
(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—
(1) SELECTION OF QUALIFIED EXTERNAL REVIEW ENTITIES.—
(A) LIMITATION ON PLAN OR ISSUER SELECTION.—The appropriate Secretary shall implement procedures—
(i) to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner; and
(ii) for auditing a sample of decisions by such entities to assure that such decisions are made in a unbiased manner.
No such selection process under the procedures implemented by the appropriate Secretary may involve any person or plan or issuer any ability to determine or influence the selection of a qualified external review entity for the case of any participant, beneficiary, or enrollee.
(B) STATE AUTHORITY WITH RESPECT TO QUALIFIED EXTERNAL REVIEW ENTITIES 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 under a contract between the plan or issuer under this section and a qualified external review 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) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities selected by the State (or a State approved by the appropriate Secretary), including that it will provide information in a timely manner under this section.
(B) INDEPENDENCE REQUIREMENTS.—
(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—
(A) is not a related party (as defined in subsection (g)(7));
(B) does not have a material familial, financial, or professional relationship with such a party; and
(C) does not otherwise have a conflict of interest with such a party (as determined under regulations).
(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified external review entity of compensation from a plan or issuer for external review activities under this section if the compensation is provided consistent with clause (ii).
(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—
(A) 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 review activities; and
(B) provide that the costs of the external review process shall be borne by the plan or issuer.
Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(v) or costs incurred by the participant, beneficiary, or enrollee (or authorized representative) or providing for independent medical reviews under subsection (d).
(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or a professional or trade association of plans or issuers or of health care providers.
(iii) The entity has provided assurances that it will conduct external review activities consistent with the applicable requirements of this section and standards specified by the Secretary, including that it will provide information and recertification of a qualified external review entity under this section.
(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—
(1) SELECTION OF QUALIFIED EXTERNAL REVIEW ENTITIES.—The appropriate Secretary shall implement procedures—
(i) to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner; and
(ii) for auditing a sample of decisions by such entities to assure that such decisions are made in a unbiased manner.
No such selection process under the procedures implemented by the appropriate Secretary may involve any person or plan or issuer any ability to determine or influence the selection of a qualified external review entity for the case of any participant, beneficiary, or enrollee.
(B) STATE AUTHORITY WITH respect to QUALIFIED EXTERNAL REVIEW ENTITIES 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 under a contract between the plan or issuer under this section and a qualified external review 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) CONTRACT with QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).
(3) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—
(A) 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 review activities; and
(B) provide that the costs of the external review process shall be borne by the plan or issuer.
Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(v) or costs incurred by the participant, beneficiary, or enrollee (or authorized representative) or providing for independent medical reviews under subsection (d).
(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or a professional or trade association of plans or issuers or of health care providers.
(iii) The entity has provided assurances that it will conduct external review activities consistent with the applicable requirements of this section and standards specified in subparagraph (C), including that it will provide information and recertification of a qualified external review entity in a case unless the independence requirements of subparagraph (B) are met with respect to the case.
(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).
(v) The entity meets such other requirements as the appropriate Secretary provides by regulation.
(i) INDEPENDENCE REQUIREMENTS.—
(A) The plan, plan sponsor, or issuer in connection with reviews under this section shall—
(i) not exceed a reasonable level; and
(ii) not be contingent on any decision rendered by the entity or by any independent medical reviewer.
(B) CERTIFICATION AND RECERTIFICATION PROCESS.—
(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—
(A) under a process that is recognized or approved by the appropriate Secretary; or
(B) by a qualified private sector-setting organization that is approved by the appropriate Secretary under clause (ii).
(C) CERTIFICATION and RECERTIFICATION process.—
(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—
(A) under a process that is recognized or approved by the appropriate Secretary; or
(B) by a qualified private sector-setting organization that is approved by the appropriate Secretary under clause (ii).
In taking action under subclause (I), the appropriate Secretary shall give deference to entities that are under contract with the Federal Government or with an applicable State authority to perform functions of the type performed by qualified external review entities.
(ii) PROCESS.—The appropriate Secretary shall not recognize or approve a process under clause (I)(i) unless the process applies standards (as promulgated in regulations) that ensure that a qualified external review entity—
(A) will carry out (and has carried out, in the case of recertification) the responsibilities of such an entity in accordance with this section, including meeting applicable deadlines; and
(B) will meet (and has met, in the case of recertification) appropriate indicators of fiscal integrity;
(iii) will maintain (and has maintained, in the case of continuing to provide such services after the effective date referred to in this section) a list of all such review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

(ii) INFORMATION TO BE INCLUDED.—The information described in this subsection with respect to an entity is as follows:

(I) The number and types of denials for which a request for review has been received by the entity.

(II) The disposition by the entity of such denials, including the number referred to a independent medical reviewer and the reasons for such dispositions (including the application of exclusions of any plan or issuer specific basis and on a health care specialty specific basis.

(iii) The length of time in making determinations with respect to such denials.

(iv) Updated information on the information required to be submitted as a condition of certification with respect to the entity's performance of the activities described in this subsection (D).

(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—In the case of a qualified external review entity under this paragraph, the appropriate Secretary or organization conducting the recertification shall review compliance of the entity with the requirements for conducting external review activities under this section, including the following:

(I) Provision of information under subparagraph (D).

(ii) Difference in applicable deadlines (both by the entity and by independent medical reviewers it refers cases to).

(iii) Compliance with limitations on compensation, with respect to both the entity and independent medical reviewers it refers cases to.

(iv) Compliance with applicable independence requirements.

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review.

(W) Conduct oversight of qualified external review entities, including recertification of such entities, and shall be made available to the public in an appropriate manner.

(X) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is employed by any such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State or governmental subdivision thereof if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 105(d), the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning:

(A) the information that is provided under paragraph (3)(D);

(B) the number of denials that have been upheld by independent medical reviewers and the number of denials that have been reversed by such reviewers; and

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

SEC. 105. HEALTH CARE CONSUMER ASSISTANCE FUND.

(1) GRANTS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish a fund to be known as the "Health Care Consumer Assistance Fund", to be used to award grants to eligible States to carry out consumer assistance activities (including activities established by States prior to the enactment of this Act) designed to provide information, assistance, and referrals to consumers of health insurance products.

(B) STATE ELIGIBILITY.—To be eligible to receive a grant under this subsection a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes—

(A) the manner in which the State will establish within the State covered under a grant assistance office (established under paragraph (4)) will educate and assist health care consumers accessing needed care;

(B) the manner in which the State will coordinate and distinguish the services provided by the health care consumer assistance office and services provided by Federal, State and local health-related ombudsmen, information, protection and advocacy, insurance, and fraud and abuse programs;

(C) the manner in which the State will provide information, outreach, and services to underserved, minority populations with limited English proficiency and populations residing in rural areas;

(D) the manner in which the State will oversee the health care consumer assistance office, its activities, product materials and evaluate program effectiveness;

(E) the manner in which the State will ensure that funds made available under this section will be used to supplement, and not supplant, any other Federal, State, or local funds expended to provide services for programs described under this section and those described in subparagraphs (C) and (D);

(F) the manner in which the State will ensure that health care consumer office personnel have the professional background and training to carry out the activities of the office; and

(G) the manner in which the State will ensure that consumers have direct access to consumer assistance personnel during regular business hours.

(3) AMOUNT OF GRANT.—

(A) IN GENERAL.—From amounts appropriated under subsection (b) for a fiscal year, the Secretary shall award a grant to a State in an amount that bears the same ratio to such amounts as the number of individuals within the State covered under a group health plan or under health insurance coverage offered by a health insurance issuer bears to the total number of individuals so covered in all States (as determined by the Secretary). Any amounts provided to a State under this subsection that are not used by the State shall be reallocated by the Secretary and reallocated in accordance with this subparagraph.

(B) MINIMUM AMOUNT.—In no case shall the amount provided to a State under a grant under this subsection for a fiscal year be less than an amount equal to 0.5 percent of the amount appropriated for such fiscal year to carry out this section.

(C) NON-FEDERAL CONTRIBUTIONS.—A State will provide for the collection of non-Federal contributions for the operation of the office established under this section and such contributions shall be at least 28 percent of the amount of Federal funds provided to the State under this section.

(4) PROVISION OF FUNDS FOR ESTABLISHMENT OF OFFICE.—

(A) IN GENERAL.—From amounts provided under a grant under this subsection, a State...
shall, directly or through a contract with an independent entity, provide the necessary experience in serving the needs of health care consumers, provide for the establishment and operation of a State health care consumer assistance office.

(b) Eligibility for Grant.—To be eligible to enter into a contract under subparagraph (A), an entity shall demonstrate that it has the technical, organizational, and professional capacity to deliver the services described in subsection (b) to all public and private health insurance participants, beneficiaries, and enrollees.

(c) Existing State Entity.—Nothing in this section shall prevent the funding of an existing health care consumer assistance program that otherwise meets the requirements of this section.

(d) Use of Funds.—

(1) By State.—A State shall use amounts provided under this grant to—

(A) establish and implement procedures and protocols, consistent with applicable Federal and State laws, to ensure the confidentiality of all information shared by a participant, beneficiary, or enrollee, their personal representative and their health care providers, group health plans, or health insurance issuers with the office with respect to the manner in which health information may be used or disclosed to carry out consumer assistance activities. The office shall provide health care providers, group health plans, or health insurance issuers with a written authorization for the release of information and assistance according to section 164.508 of title 45, Code of Federal Regulations (as amended) or a comparable authorization (as defined in section 1395w-205 of title 42, United States Code), or any other Federal or State law.

(B) provide funds for the operation of a toll-free telephone service, under a group health plan or health insurance coverage, that 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 that enter into contracts with the health insurance issuer or group health plan to provide such services.

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

SEC. 111. CONSUMER CHOICE OPTION.

(a) In General.—

(1) a health insurance issuer providing health insurance coverage in connection with a group health plan offers to enrollees health insurance coverage 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 that have entered into contracts with the issuer to provide such services,

(2) a group health plan offers to participants health insurance coverage 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 that have entered into contracts with the issuer to provide such services, or

(3) the state sponsors or group health plans through the plan for health care, and the effectiveness of such activities and the effectiveness of such activities and the effectiveness of such activities and the effectiveness of such activities are complied with by the office.

(b) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

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, or 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, 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, or enrollee to designate any participating primary care provider who is available to accept such individual.

(2) Limitation.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, enrollees of high specialty care, pursuant to subsection (c) and (d) of section 114 (relating to access to specialty care).
CONGRESSIONAL RECORD—SENATE

July 9, 2001

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) Definition 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 benefit to services in an emergency department of a hospital, the plan or issuer shall cover emergency ambulance services (as described in paragraph (2)) furnished under the plan or coverage under the same terms and conditions (including the dollar amount of the coinsurance, copayment, or deductible) that apply to other services furnished under the plan or coverage (as defined in subsection (a)(1) under which coverage is provided for emergency services.

(2) EMMERGENCY AMBULANCE SERVICES.—For purposes of this section, the term "emergency ambulance services" means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished under the plan or coverage to receive 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, see impairement of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 114. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

(1) IN GENERAL.—A group health plan or health insurance coverage offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is covered by the plan or coverage.

(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a plan or issuer from providing such specialty care be provided at no additional cost to the participant, beneficiary, or enrollee.

(b) ACCESS TO CERTAIN PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating provider pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee.

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

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

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

(d) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialty care be provided in a treatment plan, if the plan or issuer—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the primary care provider, and the participant, beneficiary, or enrollee;

(ii) requires the use of a primary care provider; and

(iii) provides for ongoing medical care by the specialist.

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

(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan or issuer from requiring the specialist to—

(A) comply with the plan or issuer policies and procedures regarding the specialty care provided, as well as all other reasonably necessary medical information.

(B) SPECIALIST DEFINED.—For purposes of this section, the term “specialist” means, with respect to the condition of the participant, beneficiary, or enrollee, a health care provider, physician, hospital, facility, or group of such providers 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.

SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2) in the case of a female participant, beneficiary, or enrollee) if the plan or issuer would otherwise pay for such specialty care if provided by a participating specialist.

(b) APPLICATION.—A group health plan, or health insurance issuer offering health insurance coverage, described in paragraph (1) of subsection (a) of section 1867(e)(1)(A) of the Social Security Act.

(c) COVERAGE OF EMERGENCYAMBULANCE 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 In emergency medical condition, and

fits with respect to ambulance services and emergency medical condition, an emergency issue shall permit a participant, beneficiary, or enrollee who has an ongoing special condition that plan or coverage to receive a referral to a specialist for the treatment of such condition. Such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, and coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition.

(b) ONGOING SPECIAL CONDITION DEFINED.—

In this subsection, the term "ongoing special condition" means a condition or disease that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

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

(c) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialty care be provided in a treatment plan, if the plan or issuer—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the primary care provider, and the participant, beneficiary, or enrollee;

(ii) requires the use of a primary care provider; and

(iii) provides for ongoing medical care by the specialist.

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

(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan or issuer from requiring the specialist to—

(A) comply with the plan or issuer policies and procedures regarding the specialty care provided, as well as all other reasonably necessary medical information.

(B) SPECIALIST DEFINED.—For purposes of this section, the term “specialist” means, with respect to the condition of the participant, beneficiary, or enrollee, a health care provider, physician, hospital, facility, or group of such providers 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.

SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2) in the case of a female participant, beneficiary, or enrollee) if the plan or issuer would otherwise pay for such specialty care if provided by a participating specialist.

(b) APPLICATION.—A group health plan, or health insurance issuer offering health insurance coverage, described in paragraph (1) of subsection (a) of section 1867(e)(1)(A) of the Social Security Act.
CONGRESSIONAL RECORD—SENATE

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider.

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

(1) preclude the group health plan or health insurance issuer involved from requiring that the health care professional (allopathic or osteopathic) who specializes in pediatrics, and a health insurance issuer is terminated from requiring that the health care provider is terminated because of the treatment of the terminal illness or its medical manifestations.

SEC. 117. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in paragraph (e)(4)), or

(B) benefits or coverage provided by a health care provider are terminated because of any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage under 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) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved in the contract, the group health plan, the health insurance issuer, and the patient’s personal health care provider, and

(B) provide the patient with an opportunity to notify the plan or issuer of the patient’s personal health care provider, and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such continuing care provider or the provider’s consent during a transitional period (as provided for under subsection (b)).

(4) CONTINUING CARE PATIENT.—For purposes of this section, the term “continuing care patient” means—

(A) a continuing care patient described in subsection (a)(4)(A) for the period under this subsection for a continuing care patient described in subsection (a)(4)(A); or

(B) a continuing care patient described in subsection (a)(4)(B) for the period under this subsection for a continuing care patient described in subsection (a)(4)(B).

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) or (a)(4)(B) shall extend for up to 90 days as determined under the treating health care professional from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(A) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(A) or (a)(4)(B) shall extend through the provision of post-partum care directly related to the delivery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (4)(A) or (a)(4)(B) shall extend for the remainder of the patient’s life for care that is 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 transitional care on a provider agreeing to the following terms and conditions:

(1) The treating health care provider agrees to the reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period under this subsection (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient 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 treating health care provider agrees to adhere to the quality assurance and standards of the plan involved in the payment for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care 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) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) CONTRACT.—The term “contract” includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

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

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

(B) any entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term “contract” includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

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

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

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(3) SERIOUS AND COMPLEX CONDITION.—The term “serious and complex condition” means, with respect to a participant, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, an ongoing special condition (as defined in subsection (a)(4)(B)).

(4) TERMINATED.—The term “terminated” includes, with respect to a contract, the expiration or renewal of the contract, but includes only that portion of the contract for failure to meet applicable quality standards or for fraud.
(a) IN GENERAL.—To the extent that a group health plan, or health insurance coverage offered by a health insurance issuer, provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan or issuer shall—

(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary;

(2) provide for disclosure of the formulary to providers; and

(3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate, and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

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

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

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply pursuant to such Act;

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply pursuant to such Act; or

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any coverage of prescription drugs or medical devices.

SEC. 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)

(B) in connection with 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 such trial; and

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

(2) PROHIBITION ON PENALTIES OR INCENTIVES.—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 research and investigations used by the National Institutes of Health; and

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

(A) will accept the individual as a participant in the trial;

(B) is in a position to provide health care services under the terms of the trial protocol with respect to treatment of such illness;

(C) and complies with the conditions described in paragraph (1).

(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) either—

(A) the individual has a life-threatening illness 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.

(2) 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

(3) the participant, beneficiary, or enrollee provides insurance coverage for benefits with respect to medical and surgical services under subparagraph (A).

(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 appropriate 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 that 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—

(A) approved and funded (which may in-clude funding through in-kind contributions) by one or more of the following:

(i) the National Institutes of Health;

(ii) a cooperative group or center of the National Institutes of Health, such as a qualified nongovernmental research entity to which the National Cancer Institute has awarded a center support grant;

(iii) either of the following if the condi-tions described in paragraph (2) are met—

(I) the Department of Veterans Affairs;

(II) the Department of Defense; or

(B) approved by the Food and Drug Administra-tion.

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

(A) to be comparable to the system of peer re-view and investigations conducted by the National Institutes of Health; and

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

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

SEC. 120. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that inpa-tient care with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physi-cian, in consultation with the patient, to medically necessary and appropriate fol-low—

(A) a mastectomy;

(B) a lumpectomy; or

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

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physi-cian and patient determine that a shorter pe-riod of hospital stay is medically appro-priate.

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health in-surance coverage, may not modify the terms and conditions of coverage based on the determination by a participant, beneficiary, or enrollee to request less than the minimum coverage required under subsection (a).

(c) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that full coverage is provided for secondary consulta-tions by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diag-nosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diag-nosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialist operators under the plan or coverage with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that full coverage is provided with respect to the additional costs to the individual by which the attending physician certifies the specialist selected by the attending physician for such purpose at no additional cost to the individual for the services necessary for such a secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual for the services necessary for such a secondary consultation.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the secondary provision of secondary consultations where the patient determines not to seek such a consultation.

(d) PROHIBITION ON PENALTIES OR INCEN- TIVES.—A group health plan, and a health in-surance issuer providing health insurance coverage, may not—
(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant, beneficiary, or enrollee in accordance with this section; (2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant, beneficiary, or enrollee for a secondary consultation that could otherwise be covered by the plan or coverage involved under subsection (c). 

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) REQUIREMENT.—

(1) DISCLOSURE.—A group health plan, and any health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure of information to participants, beneficiaries, and enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees under the group health plan or health insurance coverage.

(2) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in selecting, accessing, or changing their primary care provider, including procedures for accessing health care services and treatment. Notice of how to inquire whether a participating provider is currently accepting new patients.

(3) PROVIDER INFORMATION.—A description of any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

(4) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to prescription drugs under section 118 if such section applies.

(5) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain services from the plan or issuer and any legal remedies and appeals available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(6) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(7) 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 issued by an issuer, and any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (7)) if such sections apply.

(8) TRANSLATION SERVICES.—A summary description of any translation 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.

(9) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of 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.

(10) NOTICE OF REQUIREMENTS.—A description of any requirements of the plan or group health plan or health insurance coverage that is required under paragraph (1) if such section applies.
combination does not result in any reduction in their plan and would otherwise be provided to the recipient.

(19) AVAILABILITY OF ADDITIONAL INFORMATION.—A statement that the information described in subsection (c), and instructions on obtaining that information (including telephone numbers and, if available, Internet websites), shall be made available upon request.

(20) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker is responsible under the plan and the authority, if any, of the participant or enrollee.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee shall include for each option available under a group health plan or health insurance coverage the following:

(1) STATUS OF PROVIDERS.—The State licensure or insurer of the group health plan or health insurance coverage, the identity of each provider, and the method of any fee-for-service, salary, bundled payments, per diem, or a combination thereof, used for compensating prospective or treating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage.

(2) COMPENSATION METHODS.—A summary description by category of the applicable methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating prospective or treating health care professionals and facilities in connection with the provision of health care under the plan or coverage.

(3) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and actions) for any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

(4) ADDITIONAL APPEALS INFORMATION.—Aggregate information 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 the coverage of the issuer.

(d) MANNER OF DISCLOSURE.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(e) 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 important or 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, leaflets, or other electronic media, or through other similar means, so long as—

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

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

(i) the recipient has affirmatively consented to the disclosure of such information in such format;

(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 receives, in advance of any attempt to contact him or her by the plan or issuer through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, 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.

SEC. 122. GENETIC INFORMATION.

(a) DEFINITIONS.—In this section:

(1) FAMILY MEMBER means the term "family member" means—

(A) the spouse of the individual;

(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

(C) all other individuals related by blood to the individual or the spouse child described in subparagraph (A) or (B).

(2) GENETIC INFORMATION.—The term "genetic information" means:

(A) genetic test results, including genetic test results related to a family member of such individual;

(B) the presence of a genetic disorder or disease or disorder in family members;

(C) genetic information for purposes of diagnosis, treatment, or payment;

(TREATMENT, OR PAYMENT.—

(TREATMENT, OR PAYMENT.—

(1) NOTICE OF CONFIDENTIALITY PRACTICES .—A group health plan, or a health insurance issuer offering health insurance coverage, shall not request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to an individual or dependent.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

(1) NOTICE OF CONFIDENTIALITY PRACTICES.—A group health plan, or a health insurance issuer offering health insurance coverage, shall post or provide, in writing, and in a clear and conspicuous manner, notice of the plan or issuer’s confidentiality practices, that shall include—

(A) a description of an individual’s rights with respect to predictive genetic information;

(B) the procedures established by the plan or issuer for the exercise of the individual’s rights; and

(C) a description of the right to obtain a copy of the notice of the confidentiality practices required in paragraphs (A) and (B).

(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage, shall not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage 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) in relation to the individual or a dependent of the individual.

(2) NONDISCRIMINATION IN RATE BASED ON PREDICTIVE GENETIC INFORMATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not deny eligibility or adjust premium or contribution rates on the basis of predictive genetic information concerning an individual (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).
CONGRESSIONAL RECORD—SENATE

SEC. 131. PROHIBITION OF INTERFERENCE WITH GENETIC INFORMATION.

(a) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for prompt payment of claims in accordance with the provisions of section 1395f(c)(2) of the Social Security Act (42 U.S.C. 1395f(c)(2)) to an appropriate private accreditation body, or appropriate management personnel of the plan or issuer, to the health care professional involved. For purposes of this subparagraph, a health care professional is a medical doctor, dentist, or other comparable 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, in a manner that is not designed to maintain quality or cost controls consistent with the responsibilities of the plan or issuer for the provision of health insurance coverage.

(b) NOTICE OF INTERNAL PROCEDURE.—Subsection (a) shall not apply if, with respect to the provision of health insurance coverage, the health care professional involved in an internal review or proceeding by such an agency with respect to such 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 affecting one or more patients within an institutional health care provider.

(c) APPLICABILITY.—Subsection (b) applies only to the extent that the plan or issuer, in relation to care, services, or conditions affecting one or more patients within an institutional health care provider, is required to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LI-CENSE.

(a) IN GENERAL.—A group health plan, and a health insurance issuer with respect to 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, certificate, or registration, solely on the basis of such license or registration.

(b) EXCEPTION.—Subsection (a) shall not apply if, with respect to the provision of health insurance coverage, the health care professional involved in an investigation or proceeding by such an agency with respect to such 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 affecting one or more patients within an institutional health care provider, is required to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved

SEC. 133. PROHIBITION AGAINST IMPROPER IN-CENTIVE 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 (C) of section 1395f(16) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of sub-paragraph (A) of such section are met with respect to such an arrangement.

(b) NOTICE OF INTERNAL PROCEDURE.—Subsection (a) shall apply only to the extent that the plan or issuer, in relation to care, services, or conditions affecting one or more patients within an institutional health care provider, is required to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved

SEC. 134. PAYMENT OF CLAIMS.

SEC. 135. PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.

SEC. 136. EXCERPTION AND SPECIAL RULE.

(b) EXCEPTION.—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 if any information in these procedures have been made available to the professional through distribution or posting.

(c) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) shall also 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 for the protection of confidentiality of information disclosed to the body.

(iii) the disclosure is made in an investigation or proceeding of an appropriate public regulatory agency against a protected health care professional.

(c) CONSTRUCTION.—Nothing in this section applies to the provision of health insurance coverage of a particular benefit or service to or on behalf of a participant, beneficiary, enrollee, or provider under an agreement that restricts or prohibits such coverage.

SEC. 137. PROHIBITION AGAINST IMPROPER IN-CENTIVE 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 (C) of section 1395f(16) 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 an arrangement.

(b) NOTICE OF INTERNAL PROCEDURE.—Subsection (a) shall apply only to the extent that the plan or issuer, in relation to care, services, or conditions affecting one or more patients within an institutional health care provider, is required to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved

SEC. 138. PROHIBITION AGAINST IMPROPER IN-CENTIVE 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 (C) of section 1395f(16) 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 an arrangement.

(b) NOTICE OF INTERNAL PROCEDURE.—Subsection (a) shall apply only to the extent that the plan or issuer, in relation to care, services, or conditions affecting one or more patients within an institutional health care provider, is required 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 give notice to a person 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) TERMINATION 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 PRIOR 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 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 providers to receive claims, licensure, or certification under 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 or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) 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 section 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 733 of the Employee Retirement Income Security Act of 1974.

(c) State, subdivision, or political jurisdiction.—For purposes of this title:

(1) APPLICABLE AUTHORITY.—The term ‘‘applicable authority’’ means—

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

(B) in the case of a health insurance issuer with respect to any 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 as the enforcee or enforcing such provision under section 2722(a)(2) or 2781(a)(2) of the Public Health Service Act.

(2) ENROLLMENT.—The term ‘‘enrollment’’ means respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the insurer to receive such coverage.

(3) 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, except that such term includes an employment welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such plan under section 601(a) of such Act. The term ‘‘health care professional’’ means an individual who is licensed, accredited, or certified under State law to provide 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 services to participants, beneficiaries, or enrollees.

(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, beneficiaries, or enrollees.

(6) 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, a health care provider that is not a participating health care provider with respect to such items and services.

(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) BENEFICIARY.—The term ‘‘beneficiary’’ means the participant or enrollee under group health plan or health insurance coverage.

(a) Continued Preemption with Respect to Other Health Plans.—Nothing in this title shall be construed to affect or modify the provisions of section 114 of the Employee Retirement Income Security Act of 1974 with respect to a group health plan treated as a group health plan under subsection (a)(2) of such Act or defined as such plan under section 601(a) of such Act.

(b) Construction.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this title.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and providers to receive claims, licensure, or certification under applicable Federal or State laws.

(9) HEALTH CARE PROFESSIONAL.—The term ‘‘applicable authority’’ means—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and providers to receive claims, licensure, or certification under applicable Federal or State laws.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS OR DETERMINATIONS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and providers to receive claims, licensure, or certification under applicable Federal or State laws.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and providers to receive claims, licensure, or certification under applicable Federal or State laws.

(D) CONSTRUCTIONS.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this title.

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is not a Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this title (or other substantially compliant requirements), in applying the requirements of this title section 2706 and 2751 (as applicable of the Public Health Service Act (as added by title II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ‘‘patient protection requirement’’ means a requirement under this title, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this title.

(B) PATIENT PROTECTION REQUIREMENT.—The terms ‘‘substantially compliant’’, ‘‘substantially complies’’, or ‘‘substantial compliance’’ with respect to a State law, mean that the State law substantially complies with the patient protection requirements and has a similar effect.

(C) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such in the certification may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with a patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification contains a substantial defect (and the reasons for disapproval) or that specified additional information is needed to make the certification substantially compliant (or substantially complies).
required to establish substantial compliance.

because it provides for greater protections

certification (and approval of certification)

ister the notice described in clause (i) with

ister a notice that a State has submitted a

tification under this paragraph;

shall—

be treated as a State law rather than a

law, of any State. A law of the United States

district court.

disapproval in the appropriate United States

under subparagraph (A) may challenge such

cable to the plan, issuer, participant, bene-

iciary, or enrollee that is not the subject of

visory opinion as to whether or not a stand-

participant, beneficiary, or enrollee may

date on which the provisions of this Act be-

requirements) to which the law relates.

determination under paragraph (2)(A); or

prove a certification under paragraph (1 un-

received by the Secretary.

determination described in subparagraph

(A), the Secretary shall make the determina-

tion additional information is needed to make the
determination described in subparagraph
(A), the Secretary shall make the determina-

within 60 days after the date on which such

specified additional information is re-

ceived by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall ap-

prove a certification under paragraph (1) un-

less—

(i) the State fails to provide sufficient in-

formation to enable the Secretary to make a
determination under paragraph (2)(A); or

(ii) the Secretary determines that the

State law involved does not provide for pa-

tient protections that substantially comply with

the requirements to which the law relates.

(B) STATE CHALLENGE.—A State that has a

certified plan under subsection (A) may challenge such

disapproval in the appropriate United States
district court.

(C) DISFRANCHISE TO STATES.—With respect to a

certification submitted under paragraph

(1), the Secretary shall give deference to the

State’s interpretation of the State law in-

volved and the compliance of the law with a

patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall

(i) provide a State with a notice of the de-

termination to approve or disapprove a cer-

tification under this paragraph;

(ii) promptly publish in the Federal Reg-

ister the notice described in clause (i) with

respect to the State; and

(iii) promptly publish in the Federal Reg-

ister the notice described in clause (i) with

respect to the State; and

(iv) annually publish the status of all

States with respect to certifications.

(4) CONSTRUCTION—Nothing in this sub-

section shall be construed as preventing the

certification (and approval of certification)

of a State law under this subsection solely because

such law provides greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the
date on which the provisions of this Act be-

come effective, as provided for in section 501,

a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an

advisory opinion as to whether or not a stand-

ard or requirement under a State law appli-
cable to the plan, issuer, participant, benefi-
ciary, or enrollee that is not the subject of a

certification under this subsection, is sup-

ersed by or under some other standard or requirement of State law.

(B) OPINION.—The Secretary shall issue an

advisory opinion with respect to a petition

submitted under subparagraph (A) within the

60-day period beginning on the date on which

such petition is submitted.

(d) DEFINITIONS.—For purposes of this sec-

tion:

(1) STATE LAW.—The term “State law” in-

cludes 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 any other State.

(2) STATE.—The term “State” includes a

State, the District of Columbia, Puerto Rico,
Title III—Application of Patient Protection Standards to Federal Health Care Programs

Section 301. Application of Patient Protection Standards to Federal Health Care Programs

(a) Application of Standards.—

(1) In general.—Each Federal health care program shall comply with the patient protection requirements under title I, and such requirements shall be deemed to be incorporated into this section.

(2) Cause of action relating to provision of health benefits.—Any individual who receives, or receives a benefit from, a Federal health care program shall have a cause of action against the Federal Government under sections 562(n) and 541(d) of the Employee Retirement Income Security Act of 1974, and the provisions of such sections shall be deemed to be incorporated into this section.

(3) Rules of construction.—For purposes of this subsection—

(A) each Federal health care program shall be deemed as a group health plan;

(B) the Federal Government shall be deemed to be the plan sponsor of each Federal health care program; and

(C) each enrollee for benefits under a Federal health care program shall be deemed to be a participant, beneficiary, or enrollee under that program.

Section 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 Patient Protection Act (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) Application to group health plans.—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, if the issuer is obligated to provide and make available (or provides and makes available) the information, if the issuer is obligated to provide and make available (or provides and makes available) such information.

(3) Internal Appeals.—With respect to the internal appeals process required to be established under section 102 of such Act, 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 the rules of the Secretary, if a group health plan enters into a contract with a qualified external review entity for the conduct of external appeal activities in accordance with this section, the plan shall be treated as meeting the requirements 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 of the Bipartisan Patient Protection Act, 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 insurance coverage); and

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

(6) Construction.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under title I.
would not be preempted under section 514.

(failure described in paragraph (1)(A) to the
under paragraph (1)(A) in connection with a
determination with such personal injury or death.

For purposes of this subsection, the term
'group health plan' includes a group health
plan, plan sponsor, or any health insurance issuer
offering health insurance coverage in connection
with the plan or any health insurance issuer
offering health insurance coverage in connection
with the plan.

(A) a group health plan that is self-insured
and self administered by an employer (includ-
ing an employee of such an employer acting
within the scope of employment); or

(B) a group health plan, plan sponsor, or any
health insurance issuer offering health insurance
coverage involved or the third party
administrator or other agent.

(2) CAUSE OF ACTION MUST NOT INVOLVE
MEDICALLY REVIEWABLE DECISION.—

'(A) IN GENERAL.—A cause of action is es-
tablished under paragraph (1)(A) only if the
decision referred to in paragraph (1)(A) does not
involve a medically reviewable decision.

(B) MEDICALLY REVIEWABLE DECISION.—

For purposes of this subsection, the term
'medically reviewable decision' means a de-

nial of a claim for benefits under the plan
which is described in section 104(d)(2) of the
Bipartisan Patient Protection Act of 2001
relating to medically reviewable decisions.

(C) CLAIM FOR BENEFITS; DENIAL.—The

term 'claim for benefits; denial' means a
determination with such personal injury or death.

(D) RULES OF CONSTRUCTION.—The
term 'rules of construction' means, in connection
with any form of decisionmaking or other con-
nexion with such personal injury or death.

(2) CAUSE OF ACTION MUST NOT INVOLVE
MEDICALLY REVIEWABLE DECISION.—

(a) A VAILABILITY OF FEDERAL CIVIL REM-
EDIES IN CASES NOT INVOLVING MEDICALLY
REVIEWABLE DECISIONS.—

(i) IN GENERAL.—No treating physician or
other treating health care professional of the
participant or beneficiary, including (but not lim-
ited to) the employer or plan sponsor acting
within the scope of employment, shall be liable
under paragraph (1) for the performance of, or the failure to perform, any non-
medically reviewable duty of the plan.

(ii) DEFINITION.—A group health plan de-
scribed in this clause is one that precludes
the liability (whether direct or vicarious) for

(iii) IRRELEVANCE OF CERTAIN COLLATERAL
EFFORTS MADE BY EMPLOYER OR PLAN SPON-
SOR.—For purposes of this subparagraph, an
employer or plan sponsor shall not be treat-

employee of such an employer or sponsor acting
within the scope of employment). The term
'physician or other health care professional' means a duty the discharge of which does not
include the making of a medically re-

(I) any participation by the employer or
other plan sponsor (or employee) in the se-
lection of the group health plan or health in-
surance 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 mainte-
nance of, the plan or coverage involved;

(III) any participation by the employer or
other plan sponsor (or employee) in the pro-
cess of creating, continuing, modifying, or
terminating the plan or any benefit under the
plan, or any health insurance issuer offering
health insurance coverage in connection
with the plan.

(B) RULE OF CONSTRUCTION RELATING TO
EXCLUSION FROM LIABILITY OF PHYSICIANS,
HEALTH CARE PROFESSIONALS, AND HOS-
ITALS.—Nothing in paragraph (6) or (7) shall
be construed to limit the liability (whether
direct or vicarious) of the plan sponsor, or any health insurance issuer offering
health insurance coverage in connection
with the plan.

(9) REQUIREMENT OF EXHAUSTION.—

Congressional Record—Senate
``(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

``(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively of the Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (1)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

``(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits is a proceeding under administrative remedies referred to in subparagraph (A) or of any action commenced under this subsection—

``(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

``(ii) shall not preclude any liability under subparagraph (A) and this subsection in connection with such claim.

``The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes in determining the amount of the damages awarded.

``(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

``(EE) OTHER DAMAGES.—

``(A) IN GENERAL.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this section.

``(B) ASSESSMENT OF CIVIL PENALTIES.—In addition to the remedies provided for in paragraph (1) (relating to the failure to provide contract benefits in accordance with the plan) a civil assessment, in an amount not to exceed $5,000,000, payable to the claimant, may be awarded in any action under such paragraph if the claimant establishes by a preponderance of the evidence that the failure described in paragraph (1) was carried out by the defendant in bad faith.

``(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper in connection with a group health plan.

``(D) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term ‘directed recordkeeper’ means a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title X of the Bipartisan Patient Protection Act of 2001 and whose duties do not include making decisions on claims for benefits.

``(E) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title X of the Bipartisan Patient Protection Act of 2001 and whose duties do not include making decisions on claims for benefits.

``(EE) REQUIREMENTS FOR DESIGNATED DECISIONMAKER.—(A) IN GENERAL.—Notwithstanding the designation of a decisionmaker under any provision of this title, any individual whose sole involvement with the group health plan is providing advice or administrative services to the employer or other plan sponsor relating to the selection of health insurance coverage offered in connection with the plan.

``(B) NO EFFECT ON STATE LAW.—No provision of this title shall be construed to—

``(i) limit liability that otherwise would be imposed by a participant or beneficiary under State law;

``(ii) limit the right of a participant or beneficiary under State law to bring a cause of action that is not preempted under this title.

``(C) LIMITATION.—Subparagraph (A) does not apply in connection with any designated decisionmaker unless the designated decisionmaker has failed to follow the specific instructions of the plan or the employer or other plan sponsor.

``(D) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—(A) IN GENERAL.—Notwithstanding the designation of a decisionmaker under any provision of this title, any individual whose sole involvement with the group health plan is providing advice or administrative services to the employer or other plan sponsor relating to the selection of health insurance coverage offered in connection with the plan. The tolling period shall be suspended until the designated decisionmaker has failed to follow the specific instructions of the plan or the employer or other plan sponsor.

``(E) REQUIREMENTS FOR DESIGNATED DECISIONMAKER.—(A) IN GENERAL.—Notwithstanding the designation of a decisionmaker under any provision of this title, any individual whose sole involvement with the group health plan is providing advice or administrative services to the employer or other plan sponsor relating to the selection of health insurance coverage offered in connection with the plan.

``(B) DESIGNATED DECISIONMAKER.—(i) All liability of such employer or plan sponsor (and any employee thereof acting within the scope of employment) under this title for purposes of subsection (n)(18) and section 514(d)(9), a designated decisionmaker shall be substituted for the employer or plan sponsor (or employee) in the action and may not raise any defense that the employer or plan sponsor (employee) could not raise if such a decisionmaker were not so designated.

``(C) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

``(D) PREVIOUSLY PROSECUTED 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 a cause of action 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 nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

``(ii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure;

``(EE) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF DIRECTOR BOARDS OF TRUSTEES, ETC.—Any individual who is—

``(i) a member of a board of directors of an employer or plan sponsor; or

``(ii) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

``shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

``(EE) REQUIREMENTS FOR DESIGNATED DECISIONMAKERS OF GROUP HEALTH INSURANCE ISSUERS.—(A) IN GENERAL.—For purposes of subsection (n)(18) and section 514(d)(9), a designated decisionmaker meets the requirements of this paragraph with respect to any participant or beneficiary.
(ii) assumes unconditionally all liability of the 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) occurring during the period in which the designation and subsection (n) or section 514(d)(9) is in effect relating to such partici-

Pant and beneficiary.

(iii) agrees to be substituted for the employer or plan sponsor by the action and not to raise any defense with re-

pect to such liability that the employer or plan sponsor (or employee) may not raise, and

(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant or ben-

eficiary, and

(C) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 512(b)(2) and as required under section 121(b)(19) of the BiPapatient Protection Act.

Any liability assumed by a designated deci-
decisionmaker pursuant to this subsection shall be in addition to any liability that it may otherwise have under applicable law.

(2) QUALIFICATIONS FOR DESIGNATED DECISION-

Makers.—

(A) IN GENERAL.—Subject to subparagraph (B), an entity is qualified under this para-

tapher to serve as a designated decisionmaker with respect to a group health plan if the en-

ity has the ability to assume the liability described in paragraph (1) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor and the Secretary certification of such ability. Such certification shall be provided to the Secretary in the form of a certificate of na-

turally, and terms 'claim for benefits' and 'denial of a claim for benefits' shall have the same mean-

ings as the definitions of such terms in section 502(2) of the Employee Retirement Income

Security Act of 1974 (29 U.S.C. 1144) is amended—

(A) by striking 'or' at the end of subparagraph (A);

(B) in subparagraph (B), by striking 'plan' and inserting 'plan, or'; and

(C) by adding at the end the following new subparagraph:

(4) LIMITATION ON APPOINTMENT OF TREAT-

ING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d)(9) may not be designated as a designated decisionmaker with respect to such participant or beneficiary. .

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking 'or' at the end of subparagraph (A);

(B) in subparagraph (B), by striking 'plan' and inserting 'plan, or'; and

(C) by adding at the end the following new subparagraph:

(4) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION INVOLVING MEDICALLY REVIEWABLE DECISION.—

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

(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to super-

cede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medi-

cally reviewable decision.

(B) MEDICALLY REVIEWABLE DECISION.—

For purposes of subparagraph (A), the term 'medically reviewable decision' means a de-

B) evidence of minimum capital and sur-

plus levels that are maintained by such enti-

ty to cover any losses as a result of liability arising under its service as a designated deci-

dionmaker under this part.

The appropriate amounts of liability insur-

ance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be main-

tained throughout the term for which the designation is in effect. The provisions of this paragraph in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insur-

ance issuer and that is regulated under Fed-

eral law or a State financial solvency law.

(4) LIMITATION ON APPOINTMENT OF TREAT-

ING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d)(9) is in effect relating to such partici-

pant and beneficiary.

(C) by adding at the end the following new subparagraph:

(4) LIMITATION ON APPOINTMENT OF TREAT-

ING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d)(9) is in effect relating to such partici-

pant and beneficiary.

"(ii) assumes unconditionally all liability of the 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) occurring during the period in which the designation and subsection (n) or section 514(d)(9) is in effect relating to such partici-

pant and beneficiary.

"(iii) agrees to be substituted for the employer or plan sponsor by the action and not to raise any defense with re-

pect to such liability that the employer or plan sponsor (or employee) may not raise, and

"(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant or ben-

eficiary, and

"(C) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 512(b)(2) and as required under section 121(b)(19) of the BiPapatient Protection Act.

Any liability assumed by a designated deci-
decisionmaker pursuant to this subsection shall be in addition to any liability that it may otherwise have under applicable law.

(2) QUALIFICATIONS FOR DESIGNATED DECISION-

Makers.—

(A) IN GENERAL.—Subject to subparagraph (B), an entity is qualified under this para-

tapher to serve as a designated decisionmaker with respect to a group health plan if the en-

ity has the ability to assume the liability described in paragraph (1) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor and the Secretary certification of such ability. Such certification shall be provided to the Secretary in the form of a certificate of na-

turally, and terms 'claim for benefits' and 'denial of a claim for benefits' shall have the same mean-

ings as the definitions of such terms in section 502(2) of the Employee Retirement Income

Security Act of 1974 (29 U.S.C. 1144) is amended—

(A) by striking 'or' at the end of subparagraph (A);

(B) in subparagraph (B), by striking 'plan' and inserting 'plan, or'; and

(C) by adding at the end the following new subparagraph:

(4) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION INVOLVING MEDICALLY REVIEWABLE DECISION.—

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

(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to super-

cede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medi-

cally reviewable decision.

(B) MEDICALLY REVIEWABLE DECISION.—

For purposes of subparagraph (A), the term 'medically reviewable decision' means a de-

B) evidence of minimum capital and sur-

plus levels that are maintained by such enti-

ty to cover any losses as a result of liability arising under its service as a designated deci-

dionmaker under this part.

The appropriate amounts of liability insur-

ance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be main-

tained throughout the term for which the designation is in effect. The provisions of this paragraph in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insur-

ance issuer and that is regulated under Fed-

eral law or a State financial solvency law.

(4) LIMITATION ON APPOINTMENT OF TREAT-

ING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d)(9) is in effect relating to such partici-

pant and beneficiary.

(C) by adding at the end the following new subparagraph:

(4) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION INVOLVING MEDICALLY REVIEWABLE DECISION.—

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

(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to super-

cede or otherwise alter, amend, modify, invalid-

ate, or impair any cause of action under State law of a participant or beneficiary to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medi-

cally reviewable decision.

(B) MEDICALLY REVIEWABLE DECISION.—

For purposes of subparagraph (A), the term 'medically reviewable decision' means a de-


an earlier injury.

experienced if the external review entity first
such participant or beneficiary has ex-
Patient Protection Act regarding an injury
shall not be precluded from pursuing
made by the employer or plan sponsor for
particular participant or beneficiary solely by
employer or plan sponsor to advocate
decision or in the conduct constituting the
benefits which was denied.
requirements of subparagraph (A) are met.

failure.

controls in connection with subsection (d), a cause of action may not
ensured to preclude the purchase by a group
plan involving; except to the extent that—

reason of—

any effort that may have been made
the employer or plan sponsor for
authorization of coverage for that or any
other participant or beneficiary (or any
group of participants or beneficiaries), or

any group or record sponsor for
benefits which are not covered under the

beneficiary of the benefits involved in the claim

beneficiary. Notwithstanding the award-

clause (i), the employer or plan

is required under Federal law

preventive care, or

right to do so.

with any denial of a claim for benefits of any
Paragraph (1) in connection with such claim.

Paragraph (1) shall not

failure of reopening

appeal by the independent medical

of subparagraph (A).

all liability of the employer or plan

claim for benefits that is the subject of an

decision or arrangement of excepted benefits

with subsection (b)(2); (B)

a State law which

benefit under subparagraph (D), a cause of action may not
the determination of the independent medical

eligibility or loss arising under a cause of action
described in paragraph (1)(A).

relief from liability for employer or other plan sponsor by means of des-

General.—The statute of limitations for any cause of action arising
under paragraph (1)(A) under State law

furnishes reviews during appeals

Any determination made by a reviewer in an administrative pro-
ceeding under section 104 of the Bipartisan

Admissible.—Any determination

recordkeeper for purposes of sub-

recordkeeper, if such process was not substan-

specific of the plan or the employer or

not to the extent of a cause of action which is

any party to a directed recordkeeper for purposes of sub-

recordkeeper shall not be treat-

participant in the design of any

benefit under the plan, including

not affect the duty of the independent med-

participation by the employer or

any participation by the employer or

participant or beneficiary solely by

a party to a directed recordkeeper in connec-

for purposes of clause (i), the employer or plan

recordkeeper' means, in connection with a

and should not have been known, by such

said to be engaged in direct participation because

not have been known, by such

participants in direct participation in a
department of the plan or the

a party to a directed recordkeeper in

participant or beneficiary that

the term 'late manifestation of an earlier in-

written or oral communication by an

thereof in the case of any par-

particular participant or beneficiary by the latest date

whether such claim should properly be with-

the term 'directed recordkeeper' is

claim of the group health plan or health in-

brought under paragraph (1) in connection

not to the extent of a cause of action which is

plaintiff or beneficiary in the case of any par-

the plaintiff or beneficiary. Notwithstanding the award-

participant or beneficiary has ex-

with subsection (b)(2); (B)

on behalf of all the participants or beneficiaries of a

employment) with respect to a participant

with respect to any claim for benefits or
denial thereof in the case of any par-

participant or beneficiary.

may be brought under paragraph (1) in connection

the review entity first

failure.

participant in a determination

external review entity first

outside of the plan. Such an entity shall be

specific instructions of the plan or the

regarding an injury

by the latest date

are known, by such

whether such claim should properly be with-

participant or beneficiary.

participant or beneficiary shall not be precluded from pursuing

such participant or beneficiary by the latest date

the specific instructions of the plan or the

employer or plan sponsor for

employer or plan sponsor with respect to the participant or

participant shall not be treat-

nominal damages in connection with any form of decisionmaking or other con-

appearing to know

in subsection (d) after 10 additional days after the date on

which such time period has expired and the

participant or beneficiary.

be brought under paragraph (1)(A).

so differentially as to

participant or beneficiary.

manner and should not have been known, by such

with respect to any claim for benefits or
denial thereof in the case of any par-

participant or beneficiary solely by

worker of the plan, if such process was not substan-

subject to section 104(e)(1)(A)(i), a participant or beneficiary

Employer or plan sponsor shall not be treat-

is engaged in direct participation in a
department of the plan or the

participant or beneficiary has ex-

failure.

participant or beneficiary by the latest date

participant or beneficiary that

sustained by the participant

participant or beneficiary which was not known,

participant or beneficiary by the latest date

one or more participants or beneficiaries, including

sustained by an interested party

participant or beneficiary, that such participant or beneficiary has ex-

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or denial thereof in the case of any par-

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"(B) RULES OF CONSTRUCTION.—For pur-
poses of this subparagraph, an employer or plan sponsor (or employee) shall not be
construed to be engaged in direct participation because of any form of decisionmaking or other con-

outside of the plan. Such an entity shall be

to the extent of a cause of action which is

appearing to know

whether such claim should properly be with-

participant or beneficiary.

participant or beneficiary shall not be precluded from pursuing

such participant or beneficiary by the latest date

participant or beneficiary that

sustained by the participant

participant or beneficiary which was not known,

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one or more participants or beneficiaries, including

sustained by an interested party

participant or beneficiary, that such participant or beneficiary has ex-

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or denial thereof in the case of any par-

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failure.
(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 October 1, 2002.

SEC. 403. LIMITATION ON CERTAIN ACTIONS RELATING TO GROUP HEALTH PLANS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402(a), is amended further by adding at the end the following new subsection:

"(q) LIMITATIONS ON ACTIONS RELATING TO GROUP HEALTH PLANS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), 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 118(a)(3), 119, or 120 of the Bipartisan Patient Protection Act (as incorporated under section 714), the amendments made by sections 201(a), 401, and 403 (and title I inssofar 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, 2002.

"(2) ENFORCEMENT BY SECRETARY UNAFFECTED.—Nothing in this section shall apply to all civil actions that are filed on or after January 1, 2002.

SEC. 404. LIMITATIONS ON ACTIONS RELATING TO GROUP HEALTH PLANS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 402(a)) is amended further by adding at the end the following new subsection:

"(r) LIMITATIONS ON ACTIONS RELATING TO HEALTH INSURANCE COVERAGE OFFERED IN CONNECTION WITH GROUP HEALTH PLANS.—

"(1) IN GENERAL.—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 the Bipartisan Patient Protection Act (as incorporated under section 714), the amendments made by sections 201(a), 401, and 403 (and title I inssofar 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, 2002. In this section referred to as the "general effective date.

"(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage offered by a health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2002, the amendments made by sections 201(a), 401, and 403 (and title I inssofar 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 are effective; or

"(B) the general effective date;

and shall apply not later than 1 year after 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 maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified after the enactment of this Act, the amendments made by sections 201(a), 401, and 403 (and title I inssofar 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 are effective; or

"(B) the general effective date.

"(3) OTHER PROVISIONS UNAFFECTED.—Nothing in this section shall be construed as affecting subsections (a)(1)(C) and (n) or section 514(d).

"(4) ENFORCEMENT BY SECRETARY UNAFFECTED.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

SEC. 405. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Subpart C of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following new section:

"(S) COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

"(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is non-Federal governmental plan.

"(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

SEC. 406. SENSE OF THE SENATE CONCERNING THE NONUSE OF CERTAIN UNPAID SERVICES.

It is the sense of the Senate that the court should consider the loss of a nonwage earning spouse or parent as an economic loss for the purposes of this section. Furthermore, the court should define the compensation for the loss not as minimum services, but, rather, in terms that fully compensate for the true and whole replacement cost to the family.
(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; or
   (B) require such plans or issuers to—
      (i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers; or
      (ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;
   (C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required services; or
   (D) require such plans or issuers to exclude religious nonmedical providers who provide medical and other required services.

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 nursing care provided by the provider.

3. SEC. 502. COORDINATION IN IMPLEMENTATION.
   The Secretary of Labor and the Secretary of Health and Human Services shall, ensure, through the execution of an interagency memorandum of understanding among the Federal Agencies, that—
   (1) regulations, rules, and interpretations issued by such Agencies relating to group health plans are consistent with the requirements of this title and the amendments made thereby; and
   (2) coordination of policies relating to enforcement of the requirements of this title and the amendments made thereby are administered so as to have the same effect at all times; and
   (3) coordination of policies relating to enforcement of the requirements of this title and the amendments made thereby are administered so as to have the same effect at all times.

4. SEC. 503. SEVERABILITY.
   If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made thereby, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE VI—MISCHELONEOUS PROVISIONS
SEC. 601. NO IMPACT ON SOCIAL SECURITY TRUST FUND.
   (a) In general.—Nothing in this Act (or an amendment made by this Act) shall be construed to—
      (2) require the plan to—
         (i) use medical professionals or criteria to decide patient access to religious nonmedical providers;
      (2) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required services; or
      (3) require such plans or issuers to exclude religious nonmedical providers who provide medical and other required services.

   (b) TRANSFERS.—
      (1) EXISTING FUND OR SECRETARY.—The Secretary of the Treasury shall annually estimate the amount of the transfer of such funds for inclusion in section 201 of the Social Security Act (42 U.S.C. 401).

   (c) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient as to ensure that the income and balances of such trust funds shall not be reduced as a result of the enactment of such Act.

SEC. 602. CUSTOMS USER FEES.
   Section 1305(b)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking “2003” and inserting “2011”, except that fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006.

SEC. 603. FISCAL YEAR 2002 MEDICARE PAYMENTS.
   Notwithstanding any other provision of law, any letter of credit under part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) that would otherwise be sent to the Treasury of the United States to secure the advance payment to a participating provider of reserves on September 30, 2002, by a carrier with a contract under section 1842 of that Act (42 U.S.C. 1395u) shall be sent on October 1, 2002.

SEC. 604. SENSE OF SENATE WITH RESPECT TO PARTICIPATION IN CLINICAL TRIALS AND ACCESS TO SPECIALTY CARE.
   (a) FINDINGS.—The Senate finds the following:
      (1) Breast cancer is the most common form of cancer among women, excluding skin cancers.
      (2) During 2001, 182,800 new cases of female invasive breast cancer will be diagnosed, and 40,800 women will die from the disease.
      (3) In addition, 1,400 male breast cancer cases are projected to be diagnosed, and 400 men will die from the disease.
      (4) Breast cancer is the second leading cause of cancer death among all women and the leading cause of cancer death among women between ages 40 and 55.
      (5) This year 8,600 children are expected to be diagnosed with cancer.
      (6) 1,500 children are expected to die from cancer this year.
      (7) There are approximately 333,000 people diagnosed with multiple sclerosis in the United States and 200 more cases are diagnosed each week.
      (8) Parkinson’s disease is a progressive disorder of the central nervous system affecting 1,000,000 in the United States.
      (9) An estimated 186,100 men will be diagnosed with prostate cancer this year.
      (10) 31,500 men will die from prostate cancer this year.
      (11) While information obtained from clinical trials is essential to finding cures for diseases that carry the risk of fatal results, Future efforts should be taken to protect the health and safety of adults and children who enroll in clinical trials.
      (12) While employers and health plans should be responsible for covering the routine costs associated with federally approved clinical trials and health plans should not be held legally responsible for the design, implementation, or outcome of such clinical trials, consistent with any applicable State or Federal liability statutes.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—
   (1) women and children battling life-threatening, deadly diseases, including advanced breast or ovarian cancer, should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician;
   (2) an individual should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician if—
      (A) that individual—
         (i) has a life-threatening or serious illness for which no standard treatment is effective; and
         (ii) is eligible to participate in a federally approved or funded clinical trial according to the trial protocol with respect to treatment of the illness;
      (B) that individual’s participation in the trial offers meaningful potential for significant clinical benefit for the individual; and
      (C) either—
         (1) the referring physician is a participating health care professional and has concluded that the individual’s participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A); or
         (2) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual’s participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A); and
   (3) a child with a life-threatening illness, including cancer, should be allowed to participate in a federally approved or funded clinical trial if that participation meets the requirements of paragraph (2).
   (4)75 Medicaid, Medicare, and other payment sources should be allowed to go to a cancer center capable of providing high quality care for that disease; and
   (5) a health maintenance organization’s decision that an in-network physician without the necessary expertise can provide care for a seriously ill patient, including a woman battling cancer, should be appealable to an independent, impartial body, and that this same right should be available to all Americans in need of access to high quality specialty care.

SEC. 605. SENSE OF THE SENATE REGARDING FAIR REVIEW PROCESS.
   (a) FINDINGS.—The Senate finds the following:
      (1) A fair, timely, impartial independent external appeals process is essential to any meaningful program of patient protection.
      (2) The independence and objectivity of the review organization and review process must be ensured.
      (3) It is incompatible with a fair and independent appeals process to allow a health maintenance organization to select the review organization that is entrusted with providing a neutral and unbiased medical review.
      (4) The American Arbitration Association and arbitration standards adopted under chapter 44 of title 28, United States Code (28 U.S.C. 1738-A et seq.) have proven to be an inappropriately unfair, the right of one party to a dispute to choose the judge in that dispute.
SEC. 607. DEFINITION OF BORN-ALIVE INFANT.

(a) In General.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

"§ 8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.'.

(b) Funding.—If the Secretary, in any report submitted under subsection (a), determines that more than 20,000 individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 402 of this Act shall be repealed effective on the date that is 12 months after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(b) LIMITATION WITH RESPECT TO CERTAIN PLANS.—If the Secretary, in any report submitted under subsection (a), determines that more than 90% of individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 402 of this Act shall be repealed effective on the date that is 12 months after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(c) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 2003 and 2004, the Secretary of Health and Human Services shall provide any funding as necessary to carry out any part of this section that has not been funded under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTHURE MOTION
We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on the motion to proceed to Calendar No. 17, H.R. 333, the bankruptcy reform bill:


RESOLVED, That the Senate proceed to consideration of the bankruptcy reform bill, H.R. 333, the House bankruptcy reform bill.

PRESIDENT PRO TERRIS.

The PRESIDING OFFICER (Mr. Conrad). The motion is in order.

The PRESIDING OFFICER (Mr. Wellstone). Without objection, it is so ordered.

The motion is in order.

The PRESIDING OFFICER (Mr. Wellstone). Without objection, it is so ordered.

ORDERS FOR TUESDAY, JULY 10, 2001

Mr. REID. Mr. President, I ask unanimous consent that the Senate resumes consideration of the supplemental appropriations bill tomorrow, Tuesday, at 10 a.m., there be 2 hours of concurrent debate equally divided between Senator Leadership Conference and Senator Conrad, or their designees, in relation to the lockbox amendments, No. 866 and No. 865. Further, that following the use or yielding back of time, the amendments be laid aside.

The PRESIDENTIAL OFFICER (Mr. Wellstone). Without objection, it is so ordered.

Mr. REID. Mr. President, I also announce to the Senate that there will be every attempt made to have a vote at 2:15 p.m. on this or in relation to these two amendments. We are working on that now. We were very close to having agreement on that but were unable to do it.

RESOLUTION FOR TUESDAY, JULY 10, 2001

Mr. REID. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until the hour of 10 a.m. Tuesday, July 10. I further ask consent that on Tuesday, immediately following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the supplemental appropriations bill; further, that the Senate recess from 12:30 to 2:15 for our weekly party conferences.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

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CONGRESSIONAL RECORD—SENATE

R. 333, and I will send a cloture motion is filed on that amend-