

# Calendar No. 809

106TH CONGRESS  
2D SESSION

# S. 3058

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

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## IN THE SENATE OF THE UNITED STATES

SEPTEMBER 15, 2000

Mr. KENNEDY (for himself and Mr. DASCHLE) introduced the following bill;  
which was read the first time

SEPTEMBER 18, 2000

Read the second time and placed on the calendar

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## A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Patients’ Bill of Rights Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievance and Appeals

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

Subtitle B—Access to Care

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

Subtitle C—Access to Information

- Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship

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

Subtitle E—Definitions

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

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

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

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

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

Sec. 303. Limitations on actions.

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

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

TITLE V—EFFECTIVE DATES; COORDINATION IN  
IMPLEMENTATION

Sec. 501. Effective dates.

Sec. 502. Coordination in implementation.

TITLE VI—MISCELLANEOUS PROVISIONS

Sec. 601. Health care paperwork simplification.

Sec. 602. No impact on social security trust fund.

1 **TITLE I—IMPROVING MANAGED**  
2 **CARE**

3 **Subtitle A—Grievance and Appeals**

4 **SEC. 101. UTILIZATION REVIEW ACTIVITIES.**

5 (a) COMPLIANCE WITH REQUIREMENTS.—

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

13 (2) USE OF OUTSIDE AGENTS.—Nothing in this  
14 section shall be construed as preventing a group  
15 health plan or health insurance issuer from arrang-  
16 ing through a contract or otherwise for persons or

1 entities to conduct utilization review activities on be-  
2 half of the plan or issuer, so long as such activities  
3 are conducted in accordance with a utilization review  
4 program that meets the requirements of this section.

5 (3) UTILIZATION REVIEW DEFINED.—For pur-  
6 poses of this section, the terms “utilization review”  
7 and “utilization review activities” mean procedures  
8 used to monitor or evaluate the use or coverage,  
9 clinical necessity, appropriateness, efficacy, or effi-  
10 ciency of health care services, procedures or settings,  
11 and includes prospective review, concurrent review,  
12 second opinions, case management, discharge plan-  
13 ning, or retrospective review.

14 (b) WRITTEN POLICIES AND CRITERIA.—

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

19 (2) USE OF WRITTEN CRITERIA.—

20 (A) IN GENERAL.—Such a program shall  
21 utilize written clinical review criteria developed  
22 with input from a range of appropriate actively  
23 practicing health care professionals, as deter-  
24 mined by the plan, pursuant to the program.

25 Such criteria shall include written clinical re-

1 view criteria that are based on valid clinical evi-  
2 dence where available and that are directed spe-  
3 cifically at meeting the needs of at-risk popu-  
4 lations and covered individuals with chronic  
5 conditions or severe illnesses, including gender-  
6 specific criteria and pediatric-specific criteria  
7 where available and appropriate.

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

18 (C) REVIEW OF SAMPLE OF CLAIMS DENI-  
19 ALS.—Such a program shall provide for an  
20 evaluation of the clinical appropriateness of at  
21 least a sample of denials of claims for benefits.

22 (c) CONDUCT OF PROGRAM ACTIVITIES.—

23 (1) ADMINISTRATION BY HEALTH CARE PRO-  
24 FESSIONALS.—A utilization review program shall be

1 administered by qualified health care professionals  
2 who shall oversee review decisions.

3 (2) USE OF QUALIFIED, INDEPENDENT PER-  
4 SONNEL.—

5 (A) IN GENERAL.—A utilization review  
6 program shall provide for the conduct of utiliza-  
7 tion review activities only through personnel  
8 who are qualified and have received appropriate  
9 training in the conduct of such activities under  
10 the program.

11 (B) PROHIBITION OF CONTINGENT COM-  
12 PENSATION ARRANGEMENTS.—Such a program  
13 shall not, with respect to utilization review ac-  
14 tivities, permit or provide compensation or any-  
15 thing of value to its employees, agents, or con-  
16 tractors in a manner that encourages denials of  
17 claims for benefits.

18 (C) PROHIBITION OF CONFLICTS.—Such a  
19 program shall not permit a health care profes-  
20 sional who is providing health care services to  
21 an individual to perform utilization review ac-  
22 tivities in connection with the health care serv-  
23 ices being provided to the individual.

24 (3) ACCESSIBILITY OF REVIEW.—Such a pro-  
25 gram shall provide that appropriate personnel per-

1 forming utilization review activities under the pro-  
2 gram, including the utilization review administrator,  
3 are reasonably accessible by toll-free telephone dur-  
4 ing normal business hours to discuss patient care  
5 and allow response to telephone requests, and that  
6 appropriate provision is made to receive and respond  
7 promptly to calls received during other hours.

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

14 (d) DEADLINE FOR DETERMINATIONS.—

15 (1) PRIOR AUTHORIZATION SERVICES.—

16 (A) IN GENERAL.—Except as provided in  
17 paragraph (2), in the case of a utilization re-  
18 view activity involving the prior authorization of  
19 health care items and services for an individual,  
20 the utilization review program shall make a de-  
21 termination concerning such authorization, and  
22 provide notice of the determination to the indi-  
23 vidual or the individual's designee and the indi-  
24 vidual's health care provider by telephone and  
25 in printed form, as soon as possible in accord-

1           ance with the medical exigencies of the case,  
2           and in no event later than the deadline specified  
3           in subparagraph (B).

4           (B) DEADLINE.—

5           (i) IN GENERAL.—Subject to clauses  
6           (ii) and (iii), the deadline specified in this  
7           subparagraph is 14 days after the date of  
8           receipt of the request for prior authoriza-  
9           tion.

10          (ii) EXTENSION PERMITTED WHERE  
11          NOTICE OF ADDITIONAL INFORMATION RE-  
12          QUIRED.—If a utilization review  
13          program—

14               (I) receives a request for a prior  
15               authorization;

16               (II) determines that additional  
17               information is necessary to complete  
18               the review and make the determina-  
19               tion on the request; and

20               (III) notifies the requester, not  
21               later than five business days after the  
22               date of receiving the request, of the  
23               need for such specified additional in-  
24               formation,

1 the deadline specified in this subparagraph  
2 is 14 days after the date the program re-  
3 ceives the specified additional information,  
4 but in no case later than 28 days after the  
5 date of receipt of the request for the prior  
6 authorization. This clause shall not apply  
7 if the deadline is specified in clause (iii).

8 (iii) EXPEDITED CASES.—In the case  
9 of a situation described in section  
10 102(c)(1)(A), the deadline specified in this  
11 subparagraph is 72 hours after the time of  
12 the request for prior authorization.

13 (2) ONGOING CARE.—

14 (A) CONCURRENT REVIEW.—

15 (i) IN GENERAL.—Subject to subpara-  
16 graph (B), in the case of a concurrent re-  
17 view of ongoing care (including hospitaliza-  
18 tion), which results in a termination or re-  
19 duction of such care, the plan must provide  
20 by telephone and in printed form notice of  
21 the concurrent review determination to the  
22 individual or the individual's designee and  
23 the individual's health care provider as  
24 soon as possible in accordance with the  
25 medical exigencies of the case, with suffi-

1           cient time prior to the termination or re-  
2           duction to allow for an appeal under sec-  
3           tion 102(c)(1)(A) to be completed before  
4           the termination or reduction takes effect.

5           (ii) CONTENTS OF NOTICE.—Such no-  
6           tice shall include, with respect to ongoing  
7           health care items and services, the number  
8           of ongoing services approved, the new total  
9           of approved services, the date of onset of  
10          services, and the next review date, if any,  
11          as well as a statement of the individual’s  
12          rights to further appeal.

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

17          (3) PREVIOUSLY PROVIDED SERVICES.—In the  
18          case of a utilization review activity involving retro-  
19          spective review of health care services previously pro-  
20          vided for an individual, the utilization review pro-  
21          gram shall make a determination concerning such  
22          services, and provide notice of the determination to  
23          the individual or the individual’s designee and the  
24          individual’s health care provider by telephone and in  
25          printed form, within 30 days of the date of receipt

1 of information that is reasonably necessary to make  
2 such determination, but in no case later than 60  
3 days after the date of receipt of the claim for bene-  
4 fits.

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

13 (5) REFERENCE TO SPECIAL RULES FOR EMER-  
14 GENCY SERVICES, MAINTENANCE CARE, AND POST-  
15 STABILIZATION CARE.—For waiver of prior author-  
16 ization requirements in certain cases involving emer-  
17 gency services and maintenance care and post-sta-  
18 bilization care, see subsections (a)(1) and (b) of sec-  
19 tion 113, respectively.

20 (e) NOTICE OF DENIALS OF CLAIMS FOR BENE-  
21 FITS.—

22 (1) IN GENERAL.—Notice of a denial of claims  
23 for benefits under a utilization review program shall  
24 be provided in printed form and written in a manner

1 calculated to be understood by the participant, bene-  
2 ficiary, or enrollee and shall include—

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

5 (B) instructions on how to initiate an ap-  
6 peal under section 102; and

7 (C) notice of the availability, upon request  
8 of the individual (or the individual’s designee)  
9 of the clinical review criteria relied upon to  
10 make such denial.

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

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

18 (1) CLAIM FOR BENEFITS.—The term “claim  
19 for benefits” means any request for coverage (in-  
20 cluding authorization of coverage), for eligibility, or  
21 for payment in whole or in part, for an item or serv-  
22 ice under a group health plan or health insurance  
23 coverage.

24 (2) DENIAL OF CLAIM FOR BENEFITS.—The  
25 term “denial” means, with respect to a claim for

1 benefits, a denial, or a failure to act on a timely  
2 basis upon, in whole or in part, the claim for bene-  
3 fits and includes a failure to provide benefits (in-  
4 cluding items and services) required to be provided  
5 under this title.

6 **SEC. 102. INTERNAL APPEALS PROCEDURES.**

7 (a) RIGHT OF REVIEW.—

8 (1) IN GENERAL.—Each group health plan, and  
9 each health insurance issuer offering health insur-  
10 ance coverage—

11 (A) shall provide adequate notice in writ-  
12 ing to any participant or beneficiary under such  
13 plan, or enrollee under such coverage, whose  
14 claim for benefits under the plan or coverage  
15 has been denied (within the meaning of section  
16 101(f)(2)), setting forth the specific reasons for  
17 such denial of claim for benefits and rights to  
18 any further review or appeal, written in a man-  
19 ner calculated to be understood by the partici-  
20 pant, beneficiary, or enrollee; and

21 (B) shall afford such a participant, bene-  
22 ficiary, or enrollee (and any provider or other  
23 person acting on behalf of such an individual  
24 with the individual's consent or without such  
25 consent if the individual is medically unable to

1 provide such consent) who is dissatisfied with  
2 such a denial of claim for benefits a reasonable  
3 opportunity (of not less than 180 days) to re-  
4 quest and obtain a full and fair review by a  
5 named fiduciary (with respect to such plan) or  
6 named appropriate individual (with respect to  
7 such coverage) of the decision denying the  
8 claim.

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

13 (b) INTERNAL REVIEW PROCESS.—

14 (1) CONDUCT OF REVIEW.—

15 (A) IN GENERAL.—A review of a denial of  
16 claim under this section shall be made by an in-  
17 dividual who—

18 (i) in a case involving medical judg-  
19 ment, shall be a physician or, in the case  
20 of limited scope coverage (as defined in  
21 subparagraph (B)), shall be an appropriate  
22 specialist;

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

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

3 (B) LIMITED SCOPE COVERAGE DE-  
4 FINED.—For purposes of subparagraph (A), the  
5 term “limited scope coverage” means a group  
6 health plan or health insurance coverage the  
7 only benefits under which are for benefits de-  
8 scribed in section 2791(c)(2)(A) of the Public  
9 Health Service Act (42 U.S.C. 300gg–91(c)(2)).  
10 (2) TIME LIMITS FOR INTERNAL REVIEWS.—

11 (A) IN GENERAL.—Having received such a  
12 request for review of a denial of claim, the plan  
13 or issuer shall, in accordance with the medical  
14 exigencies of the case but not later than the  
15 deadline specified in subparagraph (B), com-  
16 plete the review on the denial and transmit to  
17 the participant, beneficiary, enrollee, or other  
18 person involved a decision that affirms, re-  
19 verses, or modifies the denial. If the decision  
20 does not reverse the denial, the plan or issuer  
21 shall transmit, in printed form, a notice that  
22 sets forth the grounds for such decision and  
23 that includes a description of rights to any fur-  
24 ther appeal. Such decision shall be treated as  
25 the final decision of the plan. Failure to issue

1 such a decision by such deadline shall be treat-  
2 ed as a final decision affirming the denial of  
3 claim.

4 (B) DEADLINE.—

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

9 (ii) EXTENSION PERMITTED WHERE  
10 NOTICE OF ADDITIONAL INFORMATION RE-  
11 QUIRED.—If a group health plan or health  
12 insurance issuer—

13 (I) receives a request for internal  
14 review;

15 (II) determines that additional  
16 information is necessary to complete  
17 the review and make the determina-  
18 tion on the request; and

19 (III) notifies the requester, not  
20 later than five business days after the  
21 date of receiving the request, of the  
22 need for such specified additional in-  
23 formation,

24 the deadline specified in this subparagraph  
25 is 14 days after the date the plan or issuer

1 receives the specified additional informa-  
2 tion, but in no case later than 28 days  
3 after the date of receipt of the request for  
4 the internal review. This clause shall not  
5 apply if the deadline is specified in clause  
6 (iii).

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

12 (c) EXPEDITED REVIEW PROCESS.—

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

17 (A) in which the application of the normal  
18 timeframe for making a determination could se-  
19 riously jeopardize the life or health of the par-  
20 ticipant, beneficiary, or enrollee or such an indi-  
21 vidual's ability to regain maximum function; or

22 (B) described in section 101(d)(2) (relat-  
23 ing to requests for continuation of ongoing care  
24 which would otherwise be reduced or termi-  
25 nated).

1 (2) PROCESS.—Under such procedures—

2 (A) the request for expedited review may  
3 be submitted orally or in writing by an indi-  
4 vidual or provider who is otherwise entitled to  
5 request the review;

6 (B) all necessary information, including  
7 the plan's or issuer's decision, shall be trans-  
8 mitted between the plan or issuer and the re-  
9 quester by telephone, facsimile, or other simi-  
10 larly expeditious available method; and

11 (C) the plan or issuer shall expedite the re-  
12 view in the case of any of the situations de-  
13 scribed in subparagraph (A) or (B) of para-  
14 graph (1).

15 (3) DEADLINE FOR DECISION.—The decision on  
16 the expedited review must be made and commu-  
17 nicated to the parties as soon as possible in accord-  
18 ance with the medical exigencies of the case, and in  
19 no event later than 72 hours after the time of re-  
20 ceipt of the request for expedited review, except that  
21 in a case described in paragraph (1)(B), the decision  
22 must be made before the end of the approved period  
23 of care.

24 (d) WAIVER OF PROCESS.—A plan or issuer may  
25 waive its rights for an internal review under subsection

1 (b). In such case the participant, beneficiary, or enrollee  
 2 involved (and any designee or provider involved) shall be  
 3 relieved of any obligation to complete the review involved  
 4 and may, at the option of such participant, beneficiary,  
 5 enrollee, designee, or provider, proceed directly to seek  
 6 further appeal through any applicable external appeals  
 7 process.

8 **SEC. 103. EXTERNAL APPEALS PROCEDURES.**

9 (a) RIGHT TO EXTERNAL APPEAL.—

10 (1) IN GENERAL.—A group health plan, and a  
 11 health insurance issuer offering health insurance  
 12 coverage, shall provide for an external appeals pro-  
 13 cess that meets the requirements of this section in  
 14 the case of an externally appealable decision de-  
 15 scribed in paragraph (2), for which a timely appeal  
 16 is made either by the plan or issuer or by the partic-  
 17 ipant, beneficiary, or enrollee (and any provider or  
 18 other person acting on behalf of such an individual  
 19 with the individual’s consent or without such consent  
 20 if such an individual is medically unable to provide  
 21 such consent). The appropriate Secretary shall es-  
 22 tablish standards to carry out such requirements.

23 (2) EXTERNALLY APPEALABLE DECISION DE-  
 24 FINED.—

1 (A) IN GENERAL.—For purposes of this  
2 section, the term “externally appealable deci-  
3 sion” means a denial of claim for benefits (as  
4 defined in section 101(f)(2))—

5 (i) that is based in whole or in part on  
6 a decision that the item or service is not  
7 medically necessary or appropriate or is in-  
8 vestigational or experimental; or

9 (ii) in which the decision as to wheth-  
10 er a benefit is covered involves a medical  
11 judgment.

12 (B) INCLUSION.—Such term also includes  
13 a failure to meet an applicable deadline for in-  
14 ternal review under section 102.

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

17 (i) specific exclusions or express limi-  
18 tations on the amount, duration, or scope  
19 of coverage that do not involve medical  
20 judgment; or

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

24 (3) EXHAUSTION OF INTERNAL REVIEW PROC-  
25 ESS.—Except as provided under section 102(d), a

1 plan or issuer may condition the use of an external  
2 appeal process in the case of an externally appeal-  
3 able decision upon a final decision in an internal re-  
4 view under section 102, but only if the decision is  
5 made in a timely basis consistent with the deadlines  
6 provided under this subtitle.

7 (4) FILING FEE REQUIREMENT.—

8 (A) IN GENERAL.—Subject to subpara-  
9 graph (B), a plan or issuer may condition the  
10 use of an external appeal process upon payment  
11 to the plan or issuer of a filing fee that does  
12 not exceed \$25.

13 (B) EXCEPTION FOR INDIGENCY.—The  
14 plan or issuer may not require payment of the  
15 filing fee in the case of an individual partici-  
16 pant, beneficiary, or enrollee who certifies (in a  
17 form and manner specified in guidelines estab-  
18 lished by the Secretary of Health and Human  
19 Services) that the individual is indigent (as de-  
20 fined in such guidelines).

21 (C) REFUNDING FEE IN CASE OF SUCCESS-  
22 FUL APPEALS.—The plan or issuer shall refund  
23 payment of the filing fee under this paragraph  
24 if the recommendation of the external appeal  
25 entity is to reverse or modify the denial of a

1 claim for benefits which is the subject of the  
2 appeal.

3 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS  
4 PROCESS.—

5 (1) CONTRACT WITH QUALIFIED EXTERNAL AP-  
6 PEAL ENTITY.—

7 (A) CONTRACT REQUIREMENT.—Except as  
8 provided in subparagraph (D), the external ap-  
9 peal process under this section of a plan or  
10 issuer shall be conducted under a contract be-  
11 tween the plan or issuer and one or more quali-  
12 fied external appeal entities (as defined in sub-  
13 section (c)).

14 (B) LIMITATION ON PLAN OR ISSUER SE-  
15 LECTION.—The applicable authority shall im-  
16 plement procedures—

17 (i) to assure that the selection process  
18 among qualified external appeal entities  
19 will not create any incentives for external  
20 appeal entities to make a decision in a bi-  
21 ased manner; and

22 (ii) for auditing a sample of decisions  
23 by such entities to assure that no such de-  
24 cisions are made in a biased manner.

1 (C) OTHER TERMS AND CONDITIONS.—

2 The terms and conditions of a contract under  
3 this paragraph shall be consistent with the  
4 standards the appropriate Secretary shall estab-  
5 lish to assure there is no real or apparent con-  
6 flict of interest in the conduct of external ap-  
7 peal activities. Such contract shall provide that  
8 all costs of the process (except those incurred  
9 by the participant, beneficiary, enrollee, or  
10 treating professional in support of the appeal)  
11 shall be paid by the plan or issuer, and not by  
12 the participant, beneficiary, or enrollee. The  
13 previous sentence shall not be construed as ap-  
14 plying to the imposition of a filing fee under  
15 subsection (a)(4).

16 (D) STATE AUTHORITY WITH RESPECT  
17 QUALIFIED EXTERNAL APPEAL ENTITY FOR  
18 HEALTH INSURANCE ISSUERS.—With respect to  
19 health insurance issuers offering health insur-  
20 ance coverage in a State, the State may provide  
21 for external review activities to be conducted by  
22 a qualified external appeal entity that is des-  
23 ignated by the State or that is selected by the  
24 State in a manner determined by the State to  
25 assure an unbiased determination.

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

5                   (A) FAIR AND DE NOVO DETERMINA-  
6                   TION.—The process shall provide for a fair, de  
7                   novo determination. However, nothing in this  
8                   paragraph shall be construed as providing for  
9                   coverage of items and services for which bene-  
10                  fits are specifically excluded under the plan or  
11                  coverage.

12                  (B) STANDARD OF REVIEW.—An external  
13                  appeal entity shall determine whether the plan's  
14                  or issuer's decision is in accordance with the  
15                  medical needs of the patient involved (as deter-  
16                  mined by the entity) taking into account, as of  
17                  the time of the entity's determination, the pa-  
18                  tient's medical condition and any relevant and  
19                  reliable evidence the entity obtains under sub-  
20                  paragraph (D). If the entity determines the de-  
21                  cision is in accordance with such needs, the en-  
22                  tity shall affirm the decision and to the extent  
23                  that the entity determines the decision is not in  
24                  accordance with such needs, the entity shall re-  
25                  verse or modify the decision.

1 (C) CONSIDERATION OF PLAN OR COV-  
2 ERAGE DEFINITIONS.—In making such deter-  
3 mination, the external appeal entity shall con-  
4 sider (but not be bound by) any language in the  
5 plan or coverage document relating to the defi-  
6 nitions of the terms medical necessity, medically  
7 necessary or appropriate, or experimental, in-  
8 vestigational, or related terms.

9 (D) EVIDENCE.—

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

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

18 (II) any personal health and  
19 medical information supplied with re-  
20 spect to the individual whose denial of  
21 claim for benefits has been appealed;  
22 and

23 (III) the opinion of the individ-  
24 ual's treating physician or health care  
25 professional.

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

5                   (I) The results of studies that  
6                   meet professionally recognized stand-  
7                   ards of validity and replicability or  
8                   that have been published in peer-re-  
9                   viewed journals.

10                   (II) The results of professional  
11                   consensus conferences conducted or fi-  
12                   nanced in whole or in part by one or  
13                   more Government agencies.

14                   (III) Practice and treatment  
15                   guidelines prepared or financed in  
16                   whole or in part by Government agen-  
17                   cies.

18                   (IV) Government-issued coverage  
19                   and treatment policies.

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

23                   (VI) To the extent that the entity  
24                   determines it to be free of any conflict  
25                   of interest, the opinions of individuals

1 who are qualified as experts in one or  
2 more fields of health care which are  
3 directly related to the matters under  
4 appeal.

5 (VII) To the extent that the enti-  
6 ty determines it to be free of any con-  
7 flict of interest, the results of peer re-  
8 views conducted by the plan or issuer  
9 involved.

10 (E) DETERMINATION CONCERNING EXTER-  
11 NALLY APPEALABLE DECISIONS.—A qualified  
12 external appeal entity shall determine—

13 (i) whether a denial of claim for bene-  
14 fits is an externally appealable decision  
15 (within the meaning of subsection (a)(2));

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

18 (iii) for purposes of initiating an ex-  
19 ternal review, whether the internal review  
20 process has been completed.

21 (F) OPPORTUNITY TO SUBMIT EVI-  
22 DENCE.—Each party to an externally appeal-  
23 able decision may submit evidence related to the  
24 issues in dispute.

1 (G) PROVISION OF INFORMATION.—The  
2 plan or issuer involved shall provide timely ac-  
3 cess to the external appeal entity to information  
4 and to provisions of the plan or health insur-  
5 ance coverage relating to the matter of the ex-  
6 ternally appealable decision, as determined by  
7 the entity.

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

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

14 (ii) be made in accordance with the  
15 medical exigencies of the case involved, but  
16 in no event later than 21 days after the  
17 date (or, in the case of an expedited ap-  
18 peal, 72 hours after the time) of requesting  
19 an external appeal of the decision;

20 (iii) state, in layperson’s language, the  
21 basis for the determination, including, if  
22 relevant, any basis in the terms or condi-  
23 tions of the plan or coverage; and

24 (iv) inform the participant, bene-  
25 ficiary, or enrollee of the individual’s rights

1 (including any limitation on such rights) to  
 2 seek further review by the courts (or other  
 3 process) of the external appeal determina-  
 4 tion.

5 (I) COMPLIANCE WITH DETERMINATION.—

6 If the external appeal entity reverses or modi-  
 7 fies the denial of a claim for benefits, the plan  
 8 or issuer shall—

9 (i) upon the receipt of the determina-  
 10 tion, authorize benefits in accordance with  
 11 such determination;

12 (ii) take such actions as may be nec-  
 13 essary to provide benefits (including items  
 14 or services) in a timely manner consistent  
 15 with such determination; and

16 (iii) submit information to the entity  
 17 documenting compliance with the entity’s  
 18 determination and this subparagraph.

19 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-  
 20 TIES.—

21 (1) IN GENERAL.—For purposes of this section,  
 22 the term “qualified external appeal entity” means,  
 23 in relation to a plan or issuer, an entity that is cer-  
 24 tified under paragraph (2) as meeting the following  
 25 requirements:

1 (A) The entity meets the independence re-  
2 quirements of paragraph (3).

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

6 (C) The entity has sufficient medical, legal,  
7 and other expertise and sufficient staffing to  
8 conduct external appeal activities for the plan  
9 or issuer on a timely basis consistent with sub-  
10 section (b)(2)(G).

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

14 (2) INITIAL CERTIFICATION OF EXTERNAL AP-  
15 PEAL ENTITIES.—

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

19 (i) a group health plan, the entity  
20 must be certified (and, in accordance with  
21 subparagraph (B), periodically recertified)  
22 as meeting the requirements of paragraph  
23 (1)—

24 (I) by the Secretary of Labor;

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

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

9 (ii) a health insurance issuer oper-  
10 ating in a State, the entity must be cer-  
11 tified (and, in accordance with subpara-  
12 graph (B), periodically recertified) as  
13 meeting such requirements—

14 (I) by the applicable State au-  
15 thority (or under a process recognized  
16 or approved by such authority); or

17 (II) if the State has not estab-  
18 lished a certification and recertifi-  
19 cation process for such entities, by the  
20 Secretary of Health and Human Serv-  
21 ices, under a process recognized or ap-  
22 proved by such Secretary, or to the  
23 extent provided in subparagraph  
24 (C)(ii), by a qualified private stand-

1                   ard-setting    organization   (certified  
2                   under such subparagraph).

3                   (B) RECERTIFICATION PROCESS.—The ap-  
4                   propriate Secretary shall develop standards for  
5                   the recertification of external appeal entities.  
6                   Such standards shall include a review of—

7                   (i) the number of cases reviewed;

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

10                  (iii) the length of time in making de-  
11                  terminations on those cases;

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

16                  (v) such information as may be nec-  
17                  essary to assure the independence of the  
18                  entity from the plans or issuers for which  
19                  external appeal activities are being con-  
20                  ducted.

21                  (C) CERTIFICATION OF QUALIFIED PRI-  
22                  VATE STANDARD-SETTING ORGANIZATIONS.—

23                  (i) FOR EXTERNAL REVIEWS UNDER  
24                  GROUP HEALTH PLANS.—For purposes of  
25                  subparagraph (A)(i)(III), the Secretary of

1 Labor may provide for a process for certifi-  
2 cation (and periodic recertification) of  
3 qualified private standard-setting organiza-  
4 tions which provide for certification of ex-  
5 ternal review entities. Such an organization  
6 shall only be certified if the organization  
7 does not certify an external review entity  
8 unless it meets standards required for cer-  
9 tification of such an entity by such Sec-  
10 retary under subparagraph (A)(i)(I).

11 (ii) FOR EXTERNAL REVIEWS OF  
12 HEALTH INSURANCE ISSUERS.—For pur-  
13 poses of subparagraph (A)(ii)(II), the Sec-  
14 retary of Health and Human Services may  
15 provide for a process for certification (and  
16 periodic recertification) of qualified private  
17 standard-setting organizations which pro-  
18 vide for certification of external review en-  
19 tities. Such an organization shall only be  
20 certified if the organization does not certify  
21 an external review entity unless it meets  
22 standards required for certification of such  
23 an entity by such Secretary under subpara-  
24 graph (A)(ii)(II).

25 (3) INDEPENDENCE REQUIREMENTS.—

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

4 (i) the peer or entity does not have a  
5 familial, financial, or professional relation-  
6 ship with any related party;

7 (ii) any compensation received by such  
8 peer or entity in connection with the exter-  
9 nal review is reasonable and not contingent  
10 on any decision rendered by the peer or en-  
11 tity;

12 (iii) except as provided in paragraph  
13 (4), the plan and the issuer have no re-  
14 course against the peer or entity in connec-  
15 tion with the external review; and

16 (iv) the peer or entity does not other-  
17 wise have a conflict of interest with a re-  
18 lated party as determined under any regu-  
19 lations which the Secretary may prescribe.

20 (B) RELATED PARTY.—For purposes of  
21 this paragraph, the term “related party”  
22 means—

23 (i) with respect to—

24 (I) a group health plan or health  
25 insurance coverage offered in connec-

1                   tion with such a plan, the plan or the  
2                   health insurance issuer offering such  
3                   coverage; or

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

7                   or any plan sponsor, fiduciary, officer, di-  
8                   rector, or management employee of such  
9                   plan or issuer;

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

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

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

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

23                  (4) LIMITATION ON LIABILITY OF REVIEW-  
24                  ERS.—No qualified external appeal entity having a  
25                  contract with a plan or issuer under this part and

1 no person who is employed by any such entity or  
2 who furnishes professional services to such entity,  
3 shall be held by reason of the performance of any  
4 duty, function, or activity required or authorized  
5 pursuant to this section, to have violated any crimi-  
6 nal law, or to be civilly liable under any law of the  
7 United States or of any State (or political subdivi-  
8 sion thereof) if due care was exercised in the per-  
9 formance of such duty, function, or activity and  
10 there was no actual malice or gross misconduct in  
11 the performance of such duty, function, or activity.

12 (d) EXTERNAL APPEAL DETERMINATION BINDING  
13 ON PLAN.—The determination by an external appeal enti-  
14 ty under this section is binding on the plan and issuer  
15 involved in the determination.

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

19 (1) MONETARY PENALTIES.—In any case in  
20 which the determination of an external review entity  
21 is not followed by a group health plan, or by a  
22 health insurance issuer offering health insurance  
23 coverage, any person who, acting in the capacity of  
24 authorizing the benefit, causes such refusal may, in  
25 the discretion in a court of competent jurisdiction,

1 be liable to an aggrieved participant, beneficiary, or  
2 enrollee for a civil penalty in an amount of up to  
3 \$1,000 a day from the date on which the determina-  
4 tion was transmitted to the plan or issuer by the ex-  
5 ternal review entity until the date the refusal to pro-  
6 vide the benefit is corrected.

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

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

24 (B) to pay to the plaintiff a reasonable at-  
25 torney's fee and other reasonable costs relating

1 to the prosecution of the action on the charges  
2 on which the plaintiff prevails.

3 (3) ADDITIONAL CIVIL PENALTIES.—

4 (A) IN GENERAL.—In addition to any pen-  
5 alty imposed under paragraph (1) or (2), the  
6 appropriate Secretary may assess a civil penalty  
7 against a person acting in the capacity of au-  
8 thorizing a benefit determined by an external  
9 review entity for one or more group health  
10 plans, or health insurance issuers offering  
11 health insurance coverage, for—

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

17 (ii) any pattern or practice of re-  
18 peated violations of the requirements of  
19 this section with respect to such plan or  
20 plans or coverage.

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

1 (i) 25 percent of the aggregate value  
2 of benefits shown by the appropriate Sec-  
3 retary to have not been provided, or unlaw-  
4 fully delayed, in violation of this section  
5 under such pattern or practice; or

6 (ii) \$500,000.

7 (4) REMOVAL AND DISQUALIFICATION.—Any  
8 person acting in the capacity of authorizing benefits  
9 who has engaged in any such pattern or practice de-  
10 scribed in paragraph (3)(A) with respect to a plan  
11 or coverage, upon the petition of the appropriate  
12 Secretary, may be removed by the court from such  
13 position, and from any other involvement, with re-  
14 spect to such a plan or coverage, and may be pre-  
15 cluded from returning to any such position or in-  
16 volvement for a period determined by the court.

17 (f) PROTECTION OF LEGAL RIGHTS.—Nothing in  
18 this subtitle shall be construed as altering or eliminating  
19 any cause of action or legal rights or remedies of partici-  
20 pants, beneficiaries, enrollees, and others under State or  
21 Federal law (including sections 502 and 503 of the Em-  
22 ployee Retirement Income Security Act of 1974), includ-  
23 ing the right to file judicial actions to enforce rights.

24 **SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.**

25 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

1           (1) IN GENERAL.—A group health plan, and a  
2 health insurance issuer in connection with the provi-  
3 sion of health insurance coverage, shall establish and  
4 maintain a system to provide for the presentation  
5 and resolution of oral and written grievances  
6 brought by individuals who are participants, bene-  
7 ficiaries, or enrollees, or health care providers or  
8 other individuals acting on behalf of an individual  
9 and with the individual’s consent or without such  
10 consent if the individual is medically unable to pro-  
11 vide such consent, regarding any aspect of the plan’s  
12 or issuer’s services.

13           (2) GRIEVANCE DEFINED.—In this section, the  
14 term “grievance” means any question, complaint, or  
15 concern brought by a participant, beneficiary or en-  
16 rollee that is not a claim for benefits (as defined in  
17 section 101(f)(1)).

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

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

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

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

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

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

## 11           **Subtitle B—Access to Care**

### 12 **SEC. 111. CONSUMER CHOICE OPTION.**

13           (a) IN GENERAL.—If—

14           (1) a health insurance issuer providing health  
15 insurance coverage in connection with a group health  
16 plan offers to enrollees health insurance coverage  
17 which provides for coverage of services only if such  
18 services are furnished through health care profes-  
19 sionals and providers who are members of a network  
20 of health care professionals and providers who have  
21 entered into a contract with the issuer to provide  
22 such services, or

23           (2) a group health plan offers to participants or  
24 beneficiaries health benefits which provide for cov-  
25 erage of services only if such services are furnished

1 through health care professionals and providers who  
2 are members of a network of health care profes-  
3 sionals and providers who have entered into a con-  
4 tract with the plan to provide such services,  
5 then the issuer or plan shall also offer or arrange to be  
6 offered to such enrollees, participants, or beneficiaries (at  
7 the time of enrollment and during an annual open season  
8 as provided under subsection (c)) the option of health in-  
9 surance coverage or health benefits which provide for cov-  
10 erage of such services which are not furnished through  
11 health care professionals and providers who are members  
12 of such a network unless such enrollees, participants, or  
13 beneficiaries are offered such non-network coverage  
14 through another group health plan or through another  
15 health insurance issuer in the group market.

16 (b) ADDITIONAL COSTS.—The amount of any addi-  
17 tional premium charged by the health insurance issuer or  
18 group health plan for the additional cost of the creation  
19 and maintenance of the option described in subsection (a)  
20 and the amount of any additional cost sharing imposed  
21 under such option shall be borne by the enrollee, partici-  
22 pant, or beneficiary unless it is paid by the health plan  
23 sponsor or group health plan through agreement with the  
24 health insurance issuer.

1 (c) OPEN SEASON.—An enrollee, participant, or ben-  
2 efiary, may change to the offering provided under this  
3 section only during a time period determined by the health  
4 insurance issuer or group health plan. Such time period  
5 shall occur at least annually.

6 **SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.**

7 (a) PRIMARY CARE.—If a group health plan, or a  
8 health insurance issuer that offers health insurance cov-  
9 erage, requires or provides for designation by a partici-  
10 pant, beneficiary, or enrollee of a participating primary  
11 care provider, then the plan or issuer shall permit each  
12 participant, beneficiary, and enrollee to designate any par-  
13 ticipating primary care provider who is available to accept  
14 such individual.

15 (b) SPECIALISTS.—

16 (1) IN GENERAL.—Subject to paragraph (2), a  
17 group health plan and a health insurance issuer that  
18 offers health insurance coverage shall permit each  
19 participant, beneficiary, or enrollee to receive medi-  
20 cally necessary or appropriate specialty care, pursu-  
21 ant to appropriate referral procedures, from any  
22 qualified participating health care professional who  
23 is available to accept such individual for such care.

24 (2) LIMITATION.—Paragraph (1) shall not  
25 apply to specialty care if the plan or issuer clearly

1 informs participants, beneficiaries, and enrollees of  
2 the limitations on choice of participating health care  
3 professionals with respect to such care.

4 (3) CONSTRUCTION.—Nothing in this sub-  
5 section shall be construed as affecting the applica-  
6 tion of section 114 (relating to access to specialty  
7 care).

8 **SEC. 113. ACCESS TO EMERGENCY CARE.**

9 (a) COVERAGE OF EMERGENCY SERVICES.—

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

16 (A) without the need for any prior author-  
17 ization determination;

18 (B) whether or not the health care pro-  
19 vider furnishing such services is a participating  
20 provider with respect to such services;

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

1 (i) by a nonparticipating health care  
 2 provider with or without prior authoriza-  
 3 tion; or

4 (ii) by a participating health care pro-  
 5 vider without prior authorization,

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

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

20 (2) DEFINITIONS.—In this section:

21 (A) EMERGENCY MEDICAL CONDITION  
 22 BASED ON PRUDENT LAYPERSON STANDARD.—  
 23 The term “emergency medical condition” means  
 24 a medical condition manifesting itself by acute  
 25 symptoms of sufficient severity (including se-

1           vere pain) such that a prudent layperson, who  
2           possesses an average knowledge of health and  
3           medicine, could reasonably expect the absence  
4           of immediate medical attention to result in a  
5           condition described in clause (i), (ii), or (iii) of  
6           section 1867(e)(1)(A) of the Social Security  
7           Act.

8           (B) EMERGENCY SERVICES.—The term  
9           “emergency services” means—

10           (i) a medical screening examination  
11           (as required under section 1867 of the So-  
12           cial Security Act) that is within the capa-  
13           bility of the emergency department of a  
14           hospital, including ancillary services rou-  
15           tinely available to the emergency depart-  
16           ment to evaluate an emergency medical  
17           condition (as defined in subparagraph  
18           (A)); and

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

24           (C) STABILIZE.—The term “to stabilize”  
25           means, with respect to an emergency medical

1 condition, to provide such medical treatment of  
 2 the condition as may be necessary to assure,  
 3 within reasonable medical probability, that no  
 4 material deterioration of the condition is likely  
 5 to result from or occur during the transfer of  
 6 the individual from a facility.

7 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND  
 8 POST-STABILIZATION CARE.—In the case of services  
 9 (other than emergency services) for which benefits are  
 10 available under a group health plan, or under health insur-  
 11 ance coverage offered by a health insurance issuer, the  
 12 plan or issuer shall provide for reimbursement with re-  
 13 spect to such services provided to a participant, bene-  
 14 ficiary, or enrollee other than through a participating  
 15 health care provider in a manner consistent with sub-  
 16 section (a)(1)(C) (and shall otherwise comply with the  
 17 guidelines established under section 1852(d)(2) of the So-  
 18 cial Security Act), if the services are maintenance care or  
 19 post-stabilization care covered under such guidelines.

20 **SEC. 114. ACCESS TO SPECIALTY CARE.**

21 (a) SPECIALTY CARE FOR COVERED SERVICES.—

22 (1) IN GENERAL.—If—

23 (A) an individual is a participant or bene-  
 24 ficiary under a group health plan or an enrollee

1           who is covered under health insurance coverage  
2           offered by a health insurance issuer;

3           (B) the individual has a condition or dis-  
4           ease of sufficient seriousness and complexity to  
5           require treatment by a specialist; and

6           (C) benefits for such treatment are pro-  
7           vided under the plan or coverage,

8           the plan or issuer shall make or provide for a refer-  
9           ral to a specialist who is available and accessible to  
10          provide the treatment for such condition or disease.

11          (2) SPECIALIST DEFINED.—For purposes of  
12          this subsection, the term “specialist” means, with  
13          respect to a condition, a health care practitioner, fa-  
14          cility, or center that has adequate expertise through  
15          appropriate training and experience (including, in  
16          the case of a child, appropriate pediatric expertise)  
17          to provide high quality care in treating the condi-  
18          tion.

19          (3) CARE UNDER REFERRAL.—A group health  
20          plan or health insurance issuer may require that the  
21          care provided to an individual pursuant to such re-  
22          ferral under paragraph (1) be—

23                 (A) pursuant to a treatment plan, only if  
24                 the treatment plan is developed by the specialist  
25                 and approved by the plan or issuer, in consulta-

1           tion with the designated primary care provider  
2           or specialist and the individual (or the individ-  
3           ual's designee); and

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

7           Nothing in this subsection shall be construed as pre-  
8           venting such a treatment plan for an individual from  
9           requiring a specialist to provide the primary care  
10          provider with regular updates on the specialty care  
11          provided, as well as all necessary medical informa-  
12          tion.

13                   (4) REFERRALS TO PARTICIPATING PRO-  
14          VIDERS.—A group health plan or health insurance  
15          issuer is not required under paragraph (1) to pro-  
16          vide for a referral to a specialist that is not a par-  
17          ticipating provider, unless the plan or issuer does  
18          not have an appropriate specialist that is available  
19          and accessible to treat the individual's condition and  
20          that is a participating provider with respect to such  
21          treatment.

22                   (5) TREATMENT OF NONPARTICIPATING PRO-  
23          VIDERS.—If a plan or issuer refers an individual to  
24          a nonparticipating specialist pursuant to paragraph  
25          (1), services provided pursuant to the approved

1 treatment plan (if any) shall be provided at no addi-  
2 tional cost to the individual beyond what the indi-  
3 vidual would otherwise pay for services received by  
4 such a specialist that is a participating provider.

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

7 (1) IN GENERAL.—A group health plan, or a  
8 health insurance issuer, in connection with the provi-  
9 sion of health insurance coverage, shall have a proce-  
10 dure by which an individual who is a participant,  
11 beneficiary, or enrollee and who has an ongoing spe-  
12 cial condition (as defined in paragraph (3)) may re-  
13 quest and receive a referral to a specialist for such  
14 condition who shall be responsible for and capable of  
15 providing and coordinating the individual's care with  
16 respect to the condition. Under such procedures if  
17 such an individual's care would most appropriately  
18 be coordinated by such a specialist, such plan or  
19 issuer shall refer the individual to such specialist.

20 (2) TREATMENT FOR RELATED REFERRALS.—  
21 Such specialists shall be permitted to treat the indi-  
22 vidual without a referral from the individual's pri-  
23 mary care provider and may authorize such refer-  
24 rals, procedures, tests, and other medical services as  
25 the individual's primary care provider would other-

1 wise be permitted to provide or authorize, subject to  
2 the terms of the treatment (referred to in subsection  
3 (a)(3)(A)) with respect to the ongoing special condi-  
4 tion.

5 (3) ONGOING SPECIAL CONDITION DEFINED.—  
6 In this subsection, the term “ongoing special condi-  
7 tion” means a condition or disease that—

8 (A) is life-threatening, degenerative, or dis-  
9 abling; and

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

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

17 (c) STANDING REFERRALS.—

18 (1) IN GENERAL.—A group health plan, and a  
19 health insurance issuer in connection with the provi-  
20 sion of health insurance coverage, shall have a proce-  
21 dure by which an individual who is a participant,  
22 beneficiary, or enrollee and who has a condition that  
23 requires ongoing care from a specialist may receive  
24 a standing referral to such specialist for treatment  
25 of such condition. If the plan or issuer, or if the pri-



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

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

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

12          (2) preclude the group health plan or health in-  
13          surance issuer involved from requiring that the ob-  
14          stetrical or gynecological provider notify the primary  
15          care health care professional or the plan or issuer of  
16          treatment decisions.

17 **SEC. 116. ACCESS TO PEDIATRIC CARE.**

18          (a) PEDIATRIC CARE.—If a group health plan, or a  
19          health insurance issuer in connection with the provision  
20          of health insurance coverage, requires or provides for an  
21          enrollee to designate a participating primary care provider  
22          for a child of such enrollee, the plan or issuer shall permit  
23          the enrollee to designate a physician who specializes in pe-  
24          diatrics as the child's primary care provider.

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

5 **SEC. 117. CONTINUITY OF CARE.**

6 (a) IN GENERAL.—

7 (1) TERMINATION OF PROVIDER.—If a contract  
8 between a group health plan, or a health insurance  
9 issuer in connection with the provision of health in-  
10 surance coverage, and a health care provider is ter-  
11 minated (as defined in paragraph (3)(B)), or bene-  
12 fits or coverage provided by a health care provider  
13 are terminated because of a change in the terms of  
14 provider participation in a group health plan, and an  
15 individual who is a participant, beneficiary, or en-  
16 rollee in the plan or coverage is undergoing treat-  
17 ment from the provider for an ongoing special condi-  
18 tion (as defined in paragraph (3)(A)) at the time of  
19 such termination, the plan or issuer shall—

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

24 (B) subject to subsection (c), permit the  
25 individual to elect to continue to be covered

1 with respect to treatment by the provider of  
2 such condition during a transitional period  
3 (provided under subsection (b)).

4 (2) TREATMENT OF TERMINATION OF CON-  
5 TRACT WITH HEALTH INSURANCE ISSUER.—If a  
6 contract for the provision of health insurance cov-  
7 erage between a group health plan and a health in-  
8 surance issuer is terminated and, as a result of such  
9 termination, coverage of services of a health care  
10 provider is terminated with respect to an individual,  
11 the provisions of paragraph (1) (and the succeeding  
12 provisions of this section) shall apply under the plan  
13 in the same manner as if there had been a contract  
14 between the plan and the provider that had been ter-  
15 minated, but only with respect to benefits that are  
16 covered under the plan after the contract termi-  
17 nation.

18 (3) DEFINITIONS.—For purposes of this sec-  
19 tion:

20 (A) ONGOING SPECIAL CONDITION.—The  
21 term “ongoing special condition” has the mean-  
22 ing given such term in section 114(b)(3), and  
23 also includes pregnancy.

24 (B) TERMINATION.—The term “termi-  
25 nated” includes, with respect to a contract, the

1            expiration or nonrenewal of the contract, but  
2            does not include a termination of the contract  
3            by the plan or issuer for failure to meet applica-  
4            ble quality standards or for fraud.

5            (b) TRANSITIONAL PERIOD.—

6            (1) IN GENERAL.—Except as provided in para-  
7            graphs (2) through (4), the transitional period under  
8            this subsection shall extend up to 90 days (as deter-  
9            mined by the treating health care professional) after  
10           the date of the notice described in subsection  
11           (a)(1)(A) of the provider’s termination.

12           (2) SCHEDULED SURGERY AND ORGAN TRANS-  
13           PLANTATION.—If surgery or organ transplantation  
14           was scheduled for an individual before the date of  
15           the announcement of the termination of the provider  
16           status under subsection (a)(1)(A) or if the individual  
17           on such date was on an established waiting list or  
18           otherwise scheduled to have such surgery or trans-  
19           plantation, the transitional period under this sub-  
20           section with respect to the surgery or transplan-  
21           tation shall extend beyond the period under para-  
22           graph (1) and until the date of discharge of the indi-  
23           vidual after completion of the surgery or transplan-  
24           tation.

25           (3) PREGNANCY.—If—

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

4 (B) the provider was treating the preg-  
 5 nancy before date of the termination,  
 6 the transitional period under this subsection with re-  
 7 spect to provider's treatment of the pregnancy shall  
 8 extend through the provision of post-partum care di-  
 9 rectly related to the delivery.

10 (4) TERMINAL ILLNESS.—If—

11 (A) a participant, beneficiary, or enrollee  
 12 was determined to be terminally ill (as deter-  
 13 mined under section 1861(dd)(3)(A) of the So-  
 14 cial Security Act) at the time of a provider's  
 15 termination of participation; and

16 (B) the provider was treating the terminal  
 17 illness before the date of termination,  
 18 the transitional period under this subsection shall  
 19 extend for the remainder of the individual's life for  
 20 care directly related to the treatment of the terminal  
 21 illness or its medical manifestations.

22 (c) PERMISSIBLE TERMS AND CONDITIONS.—A  
 23 group health plan or health insurance issuer may condi-  
 24 tion coverage of continued treatment by a provider under  
 25 subsection (a)(1)(B) upon the individual notifying the plan

1 of the election of continued coverage and upon the pro-  
2 vider agreeing to the following terms and conditions:

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

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

21           (3) The provider agrees otherwise to adhere to  
22           such plan's or issuer's policies and procedures, in-  
23           cluding procedures regarding referrals and obtaining  
24           prior authorization and providing services pursuant

1 to a treatment plan (if any) approved by the plan or  
2 issuer.

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

7 **SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

8 If a group health plan, or health insurance issuer that  
9 offers health insurance coverage, provides benefits with re-  
10 spect to prescription drugs but the coverage limits such  
11 benefits to drugs included in a formulary, the plan or  
12 issuer shall—

13 (1) ensure participation of participating physi-  
14 cians and pharmacists in the development of the for-  
15 mulary;

16 (2) disclose to providers and, disclose upon re-  
17 quest under section 121(e)(5) to participants, bene-  
18 ficiaries, and enrollees, the nature of the formulary  
19 restrictions; and

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

1 **SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**  
2 **APPROVED CLINICAL TRIALS.**

3 (a) **COVERAGE.**—

4 (1) **IN GENERAL.**—If a group health plan, or  
5 health insurance issuer that is providing health in-  
6 surance coverage, provides coverage to a qualified in-  
7 dividual (as defined in subsection (b)), the plan or  
8 issuer—

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

12 (B) subject to subsection (c), may not deny  
13 (or limit or impose additional conditions on) the  
14 coverage of routine patient costs for items and  
15 services furnished in connection with participa-  
16 tion in the trial; and

17 (C) may not discriminate against the indi-  
18 vidual on the basis of the enrollee's participa-  
19 tion in such trial.

20 (2) **EXCLUSION OF CERTAIN COSTS.**—For pur-  
21 poses of paragraph (1)(B), routine patient costs do  
22 not include the cost of the tests or measurements  
23 conducted primarily for the purpose of the clinical  
24 trial involved.

25 (3) **USE OF IN-NETWORK PROVIDERS.**—If one  
26 or more participating providers is participating in a

1 clinical trial, nothing in paragraph (1) shall be con-  
2 strued as preventing a plan or issuer from requiring  
3 that a qualified individual participate in the trial  
4 through such a participating provider if the provider  
5 will accept the individual as a participant in the  
6 trial.

7 (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-  
8 poses of subsection (a), the term “qualified individual”  
9 means an individual who is a participant or beneficiary  
10 in a group health plan, or who is an enrollee under health  
11 insurance coverage, and who meets the following condi-  
12 tions:

13 (1)(A) The individual has a life-threatening or  
14 serious illness for which no standard treatment is ef-  
15 fective.

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

19 (C) The individual’s participation in the trial  
20 offers meaningful potential for significant clinical  
21 benefit for the individual.

22 (2) Either—

23 (A) the referring physician is a partici-  
24 pating health care professional and has con-  
25 cluded that the individual’s participation in

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

4 (B) the participant, beneficiary, or enrollee  
5 provides medical and scientific information es-  
6 tablishing that the individual's participation in  
7 such trial would be appropriate based upon the  
8 individual meeting the conditions described in  
9 paragraph (1).

10 (c) PAYMENT.—

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

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

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

22 (B) a nonparticipating provider, the pay-  
23 ment rate shall be at the rate the plan or issuer  
24 would normally pay for comparable services  
25 under subparagraph (A).

1 (d) APPROVED CLINICAL TRIAL DEFINED.—

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

7 (A) The National Institutes of Health.

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

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

12 (i) The Department of Veterans Af-  
13 fairs.

14 (ii) The Department of Defense.

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

21 (A) to be comparable to the system of peer  
22 review of studies and investigations used by the  
23 National Institutes of Health; and

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

4 (e) CONSTRUCTION.—Nothing in this section shall be  
5 construed to limit a plan’s or issuer’s coverage with re-  
6 spect to clinical trials.

## 7 **Subtitle C—Access to Information**

### 8 **SEC. 121. PATIENT ACCESS TO INFORMATION.**

9 (a) DISCLOSURE REQUIREMENT.—

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

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

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

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

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

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

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

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

24 (b) INFORMATION PROVIDED.—The information de-  
25 scribed in this subsection with respect to a group health

1 plan or health insurance coverage offered by a health in-  
2 surance issuer includes the following:

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

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

7 (A) covered benefits, including benefit lim-  
8 its and coverage exclusions;

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

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

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

23 (E) process for determining experimental  
24 coverage; and

25 (F) use of a prescription drug formulary.

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

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

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

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

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

13 (E) The rights and procedures for obtain-  
14 ing referrals (including standing referrals) to  
15 participating and nonparticipating providers.

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

20 (G) Any limitations imposed on the selec-  
21 tion of qualifying participating health care pro-  
22 viders, including any limitations imposed under  
23 section 112(b)(2).

24 (H) How the plan or issuer addresses the  
25 needs of participants, beneficiaries, and enroll-

1           ees and others who do not speak English or  
2           who have other special communications needs in  
3           accessing providers under the plan or coverage,  
4           including the provision of information described  
5           in this subsection and subsection (c) to such in-  
6           dividuals.

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

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

11                 (A) the appropriate use of emergency serv-  
12                 ices, including use of the 911 telephone system  
13                 or its local equivalent in emergency situations  
14                 and an explanation of what constitutes an  
15                 emergency situation;

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

18                 (C) the locations of (i) emergency depart-  
19                 ments, and (ii) other settings, in which plan  
20                 physicians and hospitals provide emergency  
21                 services and post-stabilization care.

22          (6) PERCENTAGE OF PREMIUMS USED FOR  
23          BENEFITS (LOSS-RATIOS).—In the case of health in-  
24          surance coverage only (and not with respect to group  
25          health plans that do not provide coverage through

1 health insurance coverage), a description of the over-  
2 all loss-ratio for the coverage (as defined in accord-  
3 ance with rules established or recognized by the Sec-  
4 retary of Health and Human Services).

5 (7) PRIOR AUTHORIZATION RULES.—Rules re-  
6 garding prior authorization or other review require-  
7 ments that could result in noncoverage or non-  
8 payment.

9 (8) GRIEVANCE AND APPEALS PROCEDURES.—  
10 All appeal or grievance rights and procedures under  
11 the plan or coverage, including the method for filing  
12 grievances and the time frames and circumstances  
13 for acting on grievances and appeals, who is the ap-  
14 plicable authority with respect to the plan or issuer.

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

20 (10) INFORMATION ON ISSUER.—Notice of ap-  
21 propriate mailing addresses and telephone numbers  
22 to be used by participants, beneficiaries, and enroll-  
23 ees in seeking information or authorization for treat-  
24 ment.

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

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

6           (c) INFORMATION MADE AVAILABLE UPON RE-  
7 QUEST.—The information described in this subsection is  
8 the following:

9           (1) UTILIZATION REVIEW ACTIVITIES.—A de-  
10 scription of procedures used and requirements (in-  
11 cluding circumstances, time frames, and appeal  
12 rights) under any utilization review program under  
13 section 101, including under any drug formulary  
14 program under section 118.

15           (2) GRIEVANCE AND APPEALS INFORMATION.—  
16 Information on the number of grievances and ap-  
17 peals and on the disposition in the aggregate of such  
18 matters.

19           (3) METHOD OF PHYSICIAN COMPENSATION.—  
20 A general description by category (including salary,  
21 fee-for-service, capitation, and such other categories  
22 as may be specified in regulations of the Secretary)  
23 of the applicable method by which a specified pro-  
24 spective or treating health care professional is (or

1 would be) compensated in connection with the provi-  
 2 sion of health care under the plan or coverage.

3 (4) SPECIFIC INFORMATION ON CREDENTIALS  
 4 OF PARTICIPATING PROVIDERS.—In the case of each  
 5 participating provider, a description of the creden-  
 6 tials of the provider.

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

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

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

## 15 **Subtitle D—Protecting the Doctor-** 16 **Patient Relationship**

### 17 **SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN** 18 **MEDICAL COMMUNICATIONS.**

19 (a) GENERAL RULE.—The provisions of any contract  
 20 or agreement, or the operation of any contract or agree-  
 21 ment, between a group health plan or health insurance  
 22 issuer in relation to health insurance coverage (including  
 23 any partnership, association, or other organization that  
 24 enters into or administers such a contract or agreement)  
 25 and a health care provider (or group of health care pro-

1 viders) shall not prohibit or otherwise restrict a health  
 2 care professional from advising such a participant, bene-  
 3 ficiary, or enrollee who is a patient of the professional  
 4 about the health status of the individual or medical care  
 5 or treatment for the individual's condition or disease, re-  
 6 gardless of whether benefits for such care or treatment  
 7 are provided under the plan or coverage, if the professional  
 8 is acting within the lawful scope of practice.

9 (b) NULLIFICATION.—Any contract provision or  
 10 agreement that restricts or prohibits medical communica-  
 11 tions in violation of subsection (a) shall be null and void.

12 **SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PRO-**  
 13 **VIDERS BASED ON LICENSURE.**

14 (a) IN GENERAL.—A group health plan and a health  
 15 insurance issuer offering health insurance coverage shall  
 16 not discriminate with respect to participation or indem-  
 17 nification as to any provider who is acting within the scope  
 18 of the provider's license or certification under applicable  
 19 State law, solely on the basis of such license or certifi-  
 20 cation.

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

23 (1) as requiring the coverage under a group  
 24 health plan or health insurance coverage of par-  
 25 ticular benefits or services or to prohibit a plan or

1 issuer from including providers only to the extent  
2 necessary to meet the needs of the plan's or issuer's  
3 participants, beneficiaries, or enrollees or from es-  
4 tablishing any measure designed to maintain quality  
5 and control costs consistent with the responsibilities  
6 of the plan or issuer;

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

9 (3) as requiring a plan or issuer that offers net-  
10 work coverage to include for participation every will-  
11 ing provider who meets the terms and conditions of  
12 the plan or issuer.

13 **SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE**  
14 **ARRANGEMENTS.**

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

22 (b) APPLICATION.—For purposes of carrying out  
23 paragraph (1), any reference in section 1876(i)(8) of the  
24 Social Security Act to the Secretary, an eligible organiza-  
25 tion, or an individual enrolled with the organization shall

1 be treated as a reference to the applicable authority, a  
2 group health plan or health insurance issuer, respectively,  
3 and a participant, beneficiary, or enrollee with the plan  
4 or organization, respectively.

5 (c) CONSTRUCTION.—Nothing in this section shall be  
6 construed as prohibiting all capitation and similar ar-  
7 rangements or all provider discount arrangements.

8 **SEC. 134. PAYMENT OF CLAIMS.**

9 A group health plan, and a health insurance issuer  
10 offering group health insurance coverage, shall provide for  
11 prompt payment of claims submitted for health care serv-  
12 ices or supplies furnished to a participant, beneficiary, or  
13 enrollee with respect to benefits covered by the plan or  
14 issuer, in a manner consistent with the provisions of sec-  
15 tions 1816(c)(2) and 1842(c)(2) of the Social Security Act  
16 (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), ex-  
17 cept that for purposes of this section, subparagraph (C)  
18 of section 1816(c)(2) of the Social Security Act shall be  
19 treated as applying to claims received from a participant,  
20 beneficiary, or enrollee as well as claims referred to in  
21 such subparagraph.

22 **SEC. 135. PROTECTION FOR PATIENT ADVOCACY.**

23 (a) PROTECTION FOR USE OF UTILIZATION REVIEW  
24 AND GRIEVANCE PROCESS.—A group health plan, and a  
25 health insurance issuer with respect to the provision of

1 health insurance coverage, may not retaliate against a par-  
2 ticipant, beneficiary, enrollee, or health care provider  
3 based on the participant's, beneficiary's, enrollee's or pro-  
4 vider's use of, or participation in, a utilization review proc-  
5 ess or a grievance process of the plan or issuer (including  
6 an internal or external review or appeal process) under  
7 this title.

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

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

14 (A) discloses information relating to the  
15 care, services, or conditions affecting one or  
16 more participants, beneficiaries, or enrollees of  
17 the plan or issuer to an appropriate public reg-  
18 ulatory agency, an appropriate private accredi-  
19 tation body, or appropriate management per-  
20 sonnel of the plan or issuer; or

21 (B) initiates, cooperates, or otherwise par-  
22 ticipates in an investigation or proceeding by  
23 such an agency with respect to such care, serv-  
24 ices, or conditions.

1 If an institutional health care provider is a partici-  
2 pating provider with such a plan or issuer or other-  
3 wise receives payments for benefits provided by such  
4 a plan or issuer, the provisions of the previous sen-  
5 tence shall apply to the provider in relation to care,  
6 services, or conditions affecting one or more patients  
7 within an institutional health care provider in the  
8 same manner as they apply to the plan or issuer in  
9 relation to care, services, or conditions provided to  
10 one or more participants, beneficiaries, or enrollees;  
11 and for purposes of applying this sentence, any ref-  
12 erence to a plan or issuer is deemed a reference to  
13 the institutional health care provider.

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

20 (A) the disclosure is made on the basis of  
21 personal knowledge and is consistent with that  
22 degree of learning and skill ordinarily possessed  
23 by health care professionals with the same li-  
24 censure or certification and the same experi-  
25 ence;

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

3 (C) the information evidences either a vio-  
4 lation of a law, rule, or regulation, of an appli-  
5 cable accreditation standard, or of a generally  
6 recognized professional or clinical standard or  
7 that a patient is in imminent hazard of loss of  
8 life or serious injury; and

9 (D) subject to subparagraphs (B) and (C)  
10 of paragraph (3), the professional has followed  
11 reasonable internal procedures of the plan,  
12 issuer, or institutional health care provider es-  
13 tablished for the purpose of addressing quality  
14 concerns before making the disclosure.

15 (3) EXCEPTION AND SPECIAL RULE.—

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

22 (B) NOTICE OF INTERNAL PROCEDURES.—  
23 Subparagraph (D) of paragraph (2) shall not  
24 apply unless the internal procedures involved  
25 are reasonably expected to be known to the

1 health care professional involved. For purposes  
2 of this subparagraph, a health care professional  
3 is reasonably expected to know of internal pro-  
4 cedures if those procedures have been made  
5 available to the professional through distribu-  
6 tion or posting.

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

10 (i) the disclosure relates to an immi-  
11 nent hazard of loss of life or serious injury  
12 to a patient;

13 (ii) the disclosure is made to an ap-  
14 propriate private accreditation body pursu-  
15 ant to disclosure procedures established by  
16 the body; or

17 (iii) the disclosure is in response to an  
18 inquiry made in an investigation or pro-  
19 ceeding of an appropriate public regulatory  
20 agency and the information disclosed is  
21 limited to the scope of the investigation or  
22 proceeding.

23 (4) ADDITIONAL CONSIDERATIONS.—It shall  
24 not be a violation of paragraph (1) to take an ad-  
25 verse action against a protected health care profes-

1 sional if the plan, issuer, or provider taking the ad-  
2 verse action involved demonstrates that it would  
3 have taken the same adverse action even in the ab-  
4 sence of the activities protected under such para-  
5 graph.

6 (5) NOTICE.—A group health plan, health in-  
7 surance issuer, and institutional health care provider  
8 shall post a notice, to be provided or approved by  
9 the Secretary of Labor, setting forth excerpts from,  
10 or summaries of, the pertinent provisions of this  
11 subsection and information pertaining to enforce-  
12 ment of such provisions.

13 (6) CONSTRUCTIONS.—

14 (A) DETERMINATIONS OF COVERAGE.—

15 Nothing in this subsection shall be construed to  
16 prohibit a plan or issuer from making a deter-  
17 mination not to pay for a particular medical  
18 treatment or service or the services of a type of  
19 health care professional.

20 (B) ENFORCEMENT OF PEER REVIEW PRO-

21 TOCOLS AND INTERNAL PROCEDURES.—Noth-  
22 ing in this subsection shall be construed to pro-  
23 hibit a plan, issuer, or provider from estab-  
24 lishing and enforcing reasonable peer review or  
25 utilization review protocols or determining

1           whether a protected health care professional has  
2           complied with those protocols or from estab-  
3           lishing and enforcing internal procedures for  
4           the purpose of addressing quality concerns.

5           (C) RELATION TO OTHER RIGHTS.—Noth-  
6           ing in this subsection shall be construed to  
7           abridge rights of participants, beneficiaries, en-  
8           rollees, and protected health care professionals  
9           under other applicable Federal or State laws.

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

15                (A) with respect to a group health plan or  
16                health insurance issuer, is an employee of the  
17                plan or issuer or has a contract with the plan  
18                or issuer for provision of services for which ben-  
19                efits are available under the plan or issuer; or

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

1                   **Subtitle E—Definitions**

2   **SEC. 151. DEFINITIONS.**

3           (a) **INCORPORATION OF GENERAL DEFINITIONS.—**

4   Except as otherwise provided, the provisions of section  
5   2791 of the Public Health Service Act shall apply for pur-  
6   poses of this title in the same manner as they apply for  
7   purposes of title XXVII of such Act.

8           (b) **SECRETARY.—**Except as otherwise provided, the  
9   term “Secretary” means the Secretary of Health and  
10   Human Services, in consultation with the Secretary of  
11   Labor and the term “appropriate Secretary” means the  
12   Secretary of Health and Human Services in relation to  
13   carrying out this title under sections 2706 and 2751 of  
14   the Public Health Service Act and the Secretary of Labor  
15   in relation to carrying out this title under section 713 of  
16   the Employee Retirement Income Security Act of 1974.

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

19               (1) **ACTIVELY PRACTICING.—**The term “actively  
20   practicing” means, with respect to a physician or  
21   other health care professional, such a physician or  
22   professional who provides professional services to in-  
23   dividual patients on average at least two full days  
24   per week.

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

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

6                   (B) in the case of a health insurance issuer  
7           with respect to a specific provision of this title,  
8           the applicable State authority (as defined in  
9           section 2791(d) of the Public Health Service  
10          Act), or the Secretary of Health and Human  
11          Services, if such Secretary is enforcing such  
12          provision under section 2722(a)(2) or  
13          2761(a)(2) of the Public Health Service Act.

14          (3) CLINICAL PEER.—The term “clinical peer”  
15          means, with respect to a review or appeal, an ac-  
16          tively practicing physician (allopathic or osteopathic)  
17          or other actively practicing health care professional  
18          who holds a nonrestricted license, and who is appro-  
19          priately credentialed in the same or similar specialty  
20          or subspecialty (as appropriate) as typically handles  
21          the medical condition, procedure, or treatment under  
22          review or appeal and includes a pediatric specialist  
23          where appropriate; except that only a physician  
24          (allopathic or osteopathic) may be a clinical peer

1 with respect to the review or appeal of treatment  
2 recommended or rendered by a physician.

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

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

12 (6) HEALTH CARE PROFESSIONAL.—The term  
13 “health care professional” means an individual who  
14 is licensed, accredited, or certified under State law  
15 to provide specified health care services and who is  
16 operating within the scope of such licensure, accredi-  
17 tation, or certification.

18 (7) HEALTH CARE PROVIDER.—The term  
19 “health care provider” includes a physician or other  
20 health care professional, as well as an institutional  
21 or other facility or agency that provides health care  
22 services and that is licensed, accredited, or certified  
23 to provide health care items and services under ap-  
24 plicable State law.

1           (8) NETWORK.—The term “network” means,  
2           with respect to a group health plan or health insur-  
3           ance issuer offering health insurance coverage, the  
4           participating health care professionals and providers  
5           through whom the plan or issuer provides health  
6           care items and services to participants, beneficiaries,  
7           or enrollees.

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

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

23          (11) PRIOR AUTHORIZATION.—The term “prior  
24          authorization” means the process of obtaining prior  
25          approval from a health insurance issuer or group

1 health plan for the provision or coverage of medical  
2 services.

3 **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**  
4 **TION.**

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

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

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

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

23 (1) STATE LAW.—The term “State law” in-  
24 cludes all laws, decisions, rules, regulations, or other  
25 State action having the effect of law, of any State.

1 A law of the United States applicable only to the  
2 District of Columbia shall be treated as a State law  
3 rather than a law of the United States.

4 (2) STATE.—The term “State” includes a  
5 State, the District of Columbia, Puerto Rico, the  
6 Virgin Islands, Guam, American Samoa, the North-  
7 ern Mariana Islands, any political subdivisions of  
8 such, or any agency or instrumentality of such.

9 **SEC. 153. EXCLUSIONS.**

10 (a) NO BENEFIT REQUIREMENTS.—Nothing in this  
11 title shall be construed to require a group health plan or  
12 a health insurance issuer offering health insurance cov-  
13 erage to include specific items and services under the  
14 terms of such a plan or coverage, other than those that  
15 are provided for under the terms of such plan or coverage.

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

18 (1) IN GENERAL.—The provisions of sections  
19 111 through 117 shall not apply to a group health  
20 plan or health insurance coverage if the only cov-  
21 erage offered under the plan or coverage is fee-for-  
22 service coverage (as defined in paragraph (2)).

23 (2) FEE-FOR-SERVICE COVERAGE DEFINED.—  
24 For purposes of this subsection, the term “fee-for-

1 service coverage” means coverage under a group  
2 health plan or health insurance coverage that—

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

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

12 (C) does not restrict the selection of pro-  
13 viders among those who are lawfully authorized  
14 to provide the covered services and agree to ac-  
15 cept the terms and conditions of payment estab-  
16 lished under the plan or by the issuer; and

17 (D) for which the plan or issuer does not  
18 require prior authorization before providing cov-  
19 erage for any services.

20 **SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.**

21 Only for purposes of applying the requirements of  
22 this title under sections 2707 and 2753 of the Public  
23 Health Service Act and section 714 of the Employee Re-  
24 tirement Income Security Act of 1974, section  
25 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee

1 Retirement Income Security Act of 1974 shall be deemed  
2 not to apply.

3 **SEC. 155. REGULATIONS.**

4 The Secretaries of Health and Human Services and  
5 Labor shall issue such regulations as may be necessary  
6 or appropriate to carry out this title. Such regulations  
7 shall be issued consistent with section 104 of Health In-  
8 surance Portability and Accountability Act of 1996. Such  
9 Secretaries may promulgate any interim final rules as the  
10 Secretaries determine are appropriate to carry out this  
11 title.

12 **TITLE II—APPLICATION OF**  
13 **QUALITY CARE STANDARDS**  
14 **TO GROUP HEALTH PLANS**  
15 **AND HEALTH INSURANCE**  
16 **COVERAGE UNDER THE PUB-**  
17 **LIC HEALTH SERVICE ACT**

18 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**  
19 **GROUP HEALTH INSURANCE COVERAGE.**

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

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

24 “(a) IN GENERAL.—Each group health plan shall  
25 comply with patient protection requirements under title I

1 of the Patients' Bill of Rights Act, and each health insur-  
2 ance issuer shall comply with patient protection require-  
3 ments under such title with respect to group health insur-  
4 ance coverage it offers, and such requirements shall be  
5 deemed to be incorporated into this subsection.

6       “(b) NOTICE.—A group health plan shall comply with  
7 the notice requirement under section 711(d) of the Em-  
8 ployee Retirement Income Security Act of 1974 with re-  
9 spect to the requirements referred to in subsection (a) and  
10 a health insurance issuer shall comply with such notice  
11 requirement as if such section applied to such issuer and  
12 such issuer were a group health plan.”.

13       (b)       CONFORMING       AMENDMENT.—Section  
14 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))  
15 is amended by inserting “(other than section 2707)” after  
16 “requirements of such subparts”.

17 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**  
18 **ANCE COVERAGE.**

19       Part B of title XXVII of the Public Health Service  
20 Act is amended by inserting after section 2752 the fol-  
21 lowing new section:

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

23       “(a) IN GENERAL.—Each health insurance issuer  
24 shall comply with patient protection requirements under  
25 title I of the Patients' Bill of Rights Act with respect to

1 individual health insurance coverage it offers, and such re-  
 2 quirements shall be deemed to be incorporated into this  
 3 subsection.

4 “(b) NOTICE.—A health insurance issuer under this  
 5 part shall comply with the notice requirement under sec-  
 6 tion 711(d) of the Employee Retirement Income Security  
 7 Act of 1974 with respect to the requirements of such title  
 8 as if such section applied to such issuer and such issuer  
 9 were a group health plan.”.

10 **TITLE III—AMENDMENTS TO**  
 11 **THE EMPLOYEE RETIREMENT**  
 12 **INCOME SECURITY ACT OF**  
 13 **1974**

14 **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**  
 15 **ARDS TO GROUP HEALTH PLANS AND GROUP**  
 16 **HEALTH INSURANCE COVERAGE UNDER THE**  
 17 **EMPLOYEE RETIREMENT INCOME SECURITY**  
 18 **ACT OF 1974.**

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

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

23 “(a) IN GENERAL.—Subject to subsection (b), a  
 24 group health plan (and a health insurance issuer offering  
 25 group health insurance coverage in connection with such

1 a plan) shall comply with the requirements of title I of  
2 the Patients' Bill of Rights Act (as in effect as of the date  
3 of the enactment of such Act), and such requirements  
4 shall be deemed to be incorporated into this subsection.

5       “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-  
6 MENTS.—

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

19                       “(A) Section 112 (relating to choice of pro-  
20 viders).

21                       “(B) Section 113 (relating to access to  
22 emergency care).

23                       “(C) Section 114 (relating to access to  
24 specialty care).

1           “(D) Section 115 (relating to access to ob-  
2           stetrical and gynecological care).

3           “(E) Section 116 (relating to access to pe-  
4           diatric care).

5           “(F) Section 117(a)(1) (relating to con-  
6           tinuity in case of termination of provider con-  
7           tract) and section 117(a)(2) (relating to con-  
8           tinuity in case of termination of issuer con-  
9           tract), but only insofar as a replacement issuer  
10          assumes the obligation for continuity of care.

11          “(G) Section 118 (relating to access to  
12          needed prescription drugs).

13          “(H) Section 119 (relating to coverage for  
14          individuals participating in approved clinical  
15          trials.)

16          “(I) Section 134 (relating to payment of  
17          claims).

18          “(2) INFORMATION.—With respect to informa-  
19          tion required to be provided or made available under  
20          section 121, in the case of a group health plan that  
21          provides benefits in the form of health insurance  
22          coverage through a health insurance issuer, the Sec-  
23          retary shall determine the circumstances under  
24          which the plan is not required to provide or make  
25          available the information (and is not liable for the

1 issuer's failure to provide or make available the in-  
2 formation), if the issuer is obligated to provide and  
3 make available (or provides and makes available)  
4 such information.

5       “(3) GRIEVANCE AND INTERNAL APPEALS.—  
6 With respect to the internal appeals process and the  
7 grievance system required to be established under  
8 sections 102 and 104, in the case of a group health  
9 plan that provides benefits in the form of health in-  
10 surance coverage through a health insurance issuer,  
11 the Secretary shall determine the circumstances  
12 under which the plan is not required to provide for  
13 such process and system (and is not liable for the  
14 issuer's failure to provide for such process and sys-  
15 tem), if the issuer is obligated to provide for (and  
16 provides for) such process and system.

17       “(4) EXTERNAL APPEALS.—Pursuant to rules  
18 of the Secretary, insofar as a group health plan en-  
19 ters into a contract with a qualified external appeal  
20 entity for the conduct of external appeal activities in  
21 accordance with section 103, the plan shall be treat-  
22 ed as meeting the requirement of such section and  
23 is not liable for the entity's failure to meet any re-  
24 quirements under such section.

1           “(5) APPLICATION TO PROHIBITIONS.—Pursu-  
2           ant to rules of the Secretary, if a health insurance  
3           issuer offers health insurance coverage in connection  
4           with a group health plan and takes an action in vio-  
5           lation of any of the following sections, the group  
6           health plan shall not be liable for such violation un-  
7           less the plan caused such violation:

8                   “(A) Section 131 (relating to prohibition of  
9                   interference with certain medical communica-  
10                  tions).

11                  “(B) Section 132 (relating to prohibition  
12                  of discrimination against providers based on li-  
13                  censure).

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

16                  “(D) Section 135 (relating to protection  
17                  for patient advocacy).

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

22           “(7) APPLICATION TO CERTAIN PROHIBITIONS  
23           AGAINST RETALIATION.—With respect to compliance  
24           with the requirements of section 135(b)(1) of the  
25           Patients’ Bill of Rights Act, for purposes of this

1 subtitle the term ‘group health plan’ is deemed to in-  
2 clude a reference to an institutional health care pro-  
3 vider.

4 “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

5 “(1) COMPLAINTS.—Any protected health care  
6 professional who believes that the professional has  
7 been retaliated or discriminated against in violation  
8 of section 135(b)(1) of the Patients’ Bill of Rights  
9 Act may file with the Secretary a complaint within  
10 180 days of the date of the alleged retaliation or dis-  
11 crimination.

12 “(2) INVESTIGATION.—The Secretary shall in-  
13 vestigate such complaints and shall determine if a  
14 violation of such section has occurred and, if so,  
15 shall issue an order to ensure that the protected  
16 health care professional does not suffer any loss of  
17 position, pay, or benefits in relation to the plan,  
18 issuer, or provider involved, as a result of the viola-  
19 tion found by the Secretary.

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

24 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE  
25 REQUIREMENT.—Section 503 of such Act (29 U.S.C.

1 1133) is amended by inserting “(a)” after “SEC. 503.”  
2 and by adding at the end the following new subsection:

3 “(b) In the case of a group health plan (as defined  
4 in section 733) compliance with the requirements of sub-  
5 title A of title I of the Patients Bill of Rights Act in the  
6 case of a claims denial shall be deemed compliance with  
7 subsection (a) with respect to such claims denial.”.

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

11 (2) The table of contents in section 1 of such Act  
12 is amended by inserting after the item relating to section  
13 713 the following new item:

“Sec. 714. Patient protection standards.”.

14 (3) Section 502(b)(3) of such Act (29 U.S.C.  
15 1132(b)(3)) is amended by inserting “(other than section  
16 135(b))” after “part 7”.

17 **SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN**  
18 **ACTIONS INVOLVING HEALTH INSURANCE**  
19 **POLICYHOLDERS.**

20 (a) IN GENERAL.—Section 514 of the Employee Re-  
21 tirement Income Security Act of 1974 (29 U.S.C. 1144)  
22 (as amended by section 301(b)) is amended further by  
23 adding at the end the following subsections:

1       “(f) PREEMPTION NOT TO APPLY TO CERTAIN AC-  
2 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-  
3 FITS.—

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

6               “(A) IN GENERAL.—Except as provided in  
7 this subsection, nothing in this title shall be  
8 construed to invalidate, impair, or supersede  
9 any cause of action by a participant or bene-  
10 ficiary (or the estate of a participant or bene-  
11 ficiary) under State law to recover damages re-  
12 sulting from personal injury or for wrongful  
13 death against any person—

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

19               “(ii) that arises out of the arrange-  
20 ment by such person for the provision of  
21 such insurance, administrative services, or  
22 medical services by other persons.

23               “(B) LIMITATION ON PUNITIVE DAM-  
24 AGES.—

1           “(i) IN GENERAL.—No person shall be  
2           liable for any punitive, exemplary, or simi-  
3           lar damages in the case of a cause of ac-  
4           tion brought under subparagraph (A) if—

5                   “(I) it relates to an externally  
6                   appealable decision (as defined in sub-  
7                   section (a)(2) of section 103 of the  
8                   Patients’ Bill of Rights Act);

9                   “(II) an external appeal with re-  
10                  spect to such decision was completed  
11                  under such section 103;

12                  “(III) in the case such external  
13                  appeal was initiated by the plan or  
14                  issuer filing the request for the exter-  
15                  nal appeal, the request was filed on a  
16                  timely basis before the date the action  
17                  was brought or, if later, within 30  
18                  days after the date the externally ap-  
19                  pealable decision was made; and

20                  “(IV) the plan or issuer complied  
21                  with the determination of the external  
22                  appeal entity upon receipt of the de-  
23                  termination of the external appeal en-  
24                  tity.

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

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

10          “(C) PERSONAL INJURY DEFINED.—For  
11          purposes of this subsection, the term ‘personal  
12          injury’ means a physical injury and includes an  
13          injury arising out of the treatment (or failure  
14          to treat) a mental illness or disease.

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

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

19                 “(i) any cause of action against a  
20                 group health plan or an employer or other  
21                 plan sponsor maintaining the plan (or  
22                 against an employee of such a plan, em-  
23                 ployer, or sponsor acting within the scope  
24                 of employment), or

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

7           “(B) SPECIAL RULE.—Subparagraph (A)  
8           shall not preclude any cause of action described  
9           in paragraph (1) against group health plan or  
10          an employer or other plan sponsor (or against  
11          an employee of such a plan, employer, or spon-  
12          sor acting within the scope of employment) if—

13               “(i) such action is based on the exer-  
14               cise by the plan, employer, or sponsor (or  
15               employee) of discretionary authority to  
16               make a decision on a claim for benefits  
17               covered under the plan or health insurance  
18               coverage in the case at issue; and

19               “(ii) the exercise by the plan, em-  
20               ployer, or sponsor (or employee) of such  
21               authority resulted in personal injury or  
22               wrongful death.

23           “(C) EXCEPTION.—The exercise of discre-  
24           tionary authority described in subparagraph  
25           (B)(i) shall not be construed to include—

1                   “(i) the decision to include or exclude  
2                   from the plan any specific benefit;

3                   “(ii) any decision to provide extra-con-  
4                   tractual benefits; or

5                   “(iii) any decision not to consider the  
6                   provision of a benefit while internal or ex-  
7                   ternal review is being conducted.

8                   “(3) FUTILITY OF EXHAUSTION.—An individual  
9                   bringing an action under this subsection is required  
10                  to exhaust administrative processes under sections  
11                  102 and 103 of the Patients’ Bill of Rights Act, un-  
12                  less the injury to or death of such individual has oc-  
13                  curred before the completion of such processes.

14                  “(4) CONSTRUCTION.—Nothing in this sub-  
15                  section shall be construed as—

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

20                         “(B) as preempting a State law which re-  
21                         quires an affidavit or certificate of merit in a  
22                         civil action; or

23                         “(C) permitting a cause of action or rem-  
24                         edy under State law in connection with the pro-  
25                         vision or arrangement of excepted benefits (as

1 defined in section 733(c)), other than those de-  
 2 scribed in section 733(c)(2)(A).

3 “(g) RULES OF CONSTRUCTION RELATING TO  
 4 HEALTH CARE.—Nothing in this title shall be construed  
 5 as—

6 “(1) permitting the application of State laws  
 7 that are otherwise superseded by this title and that  
 8 mandate the provision of specific benefits by a group  
 9 health plan (as defined in section 733(a)) or a mul-  
 10 tiple employer welfare arrangement (as defined in  
 11 section 3(40)), or

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

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

19 **SEC. 303. LIMITATIONS ON ACTIONS.**

20 Section 502 of the Employee Retirement Income Se-  
 21 curity Act of 1974 (29 U.S.C. 1132) (as amended by sec-  
 22 tion 304(b)) is amended further by adding at the end the  
 23 following new subsection:

24 “(o)(1) Except as provided in this subsection, no ac-  
 25 tion may be brought under subsection (a)(1)(B), (a)(2),

1 or (a)(3) by a participant or beneficiary seeking relief  
2 based on the application of any provision in section 101,  
3 subtitle B, or subtitle D of title I of the Patients' Bill  
4 of Rights Act (as incorporated under section 714).

5       “(2) An action may be brought under subsection  
6 (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary  
7 seeking relief based on the application of section 101, 113,  
8 114, 115, 116, 117, 119, or 118(3) of the Patients' Bill  
9 of Rights Act (as incorporated under section 714) to the  
10 individual circumstances of that participant or beneficiary,  
11 except that—

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

14               “(B) in such an action, relief may only provide  
15 for the provision of (or payment of) benefits, items,  
16 or services denied to the individual participant or  
17 beneficiary involved (and for attorney's fees and the  
18 costs of the action, at the discretion of the court)  
19 and shall not provide for any other relief to the par-  
20 ticipant or beneficiary or for any relief to any other  
21 person.

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

1 **TITLE IV—APPLICATION TO**  
2 **GROUP HEALTH PLANS**  
3 **UNDER THE INTERNAL REV-**  
4 **ENUE CODE OF 1986**

5 **SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE**  
6 **OF 1986.**

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

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

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

12 and

13 (2) by inserting after section 9812 the fol-  
14 lowing:

15 **“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF**  
16 **RIGHTS.**

17 “A group health plan shall comply with the require-  
18 ments of title I of the Patients’ Bill of Rights Act (as  
19 in effect as of the date of the enactment of such Act),  
20 and such requirements shall be deemed to be incorporated  
21 into this section.”.

1 **TITLE V—EFFECTIVE DATES; CO-**  
2 **ORDINATION IN IMPLEMEN-**  
3 **TATION**

4 **SEC. 501. EFFECTIVE DATES.**

5 (a) GROUP HEALTH COVERAGE.—

6 (1) IN GENERAL.—Subject to paragraph (2),  
7 the amendments made by sections 201(a), 301, 303,  
8 and 401 (and title I insofar as it relates to such sec-  
9 tions) shall apply with respect to group health plans,  
10 and health insurance coverage offered in connection  
11 with group health plans, for plan years beginning on  
12 or after January 1, 2002 (in this section referred to  
13 as the “general effective date”) and also shall apply  
14 to portions of plan years occurring on and after such  
15 date.

16 (2) TREATMENT OF COLLECTIVE BARGAINING  
17 AGREEMENTS.—In the case of a group health plan  
18 maintained pursuant to one or more collective bar-  
19 gaining agreements between employee representa-  
20 tives and one or more employers ratified before the  
21 date of the enactment of this Act, the amendments  
22 made by sections 201(a), 301, 303, and 401 (and  
23 title I insofar as it relates to such sections) shall not  
24 apply to plan years beginning before the later of—

1 (A) the date on which the last collective  
2 bargaining agreements relating to the plan ter-  
3 minates (determined without regard to any ex-  
4 tension thereof agreed to after the date of the  
5 enactment of this Act); or

6 (B) the general effective date.

7 For purposes of subparagraph (A), any plan amend-  
8 ment made pursuant to a collective bargaining  
9 agreement relating to the plan which amends the  
10 plan solely to conform to any requirement added by  
11 this Act shall not be treated as a termination of  
12 such collective bargaining agreement.

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

18 **SEC. 502. COORDINATION IN IMPLEMENTATION.**

19 The Secretary of Labor, the Secretary of Health and  
20 Human Services, and the Secretary of the Treasury shall  
21 ensure, through the execution of an interagency memo-  
22 randum of understanding among such Secretaries, that—

23 (1) regulations, rulings, and interpretations  
24 issued by such Secretaries relating to the same mat-  
25 ter over which such Secretaries have responsibility

1 under the provisions of this Act (and the amend-  
 2 ments made thereby) are administered so as to have  
 3 the same effect at all times; and

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

## 9 **TITLE VI—MISCELLANEOUS** 10 **PROVISIONS**

### 11 **SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.**

12 (a) ESTABLISHMENT OF PANEL.—

13 (1) ESTABLISHMENT.—There is established a  
 14 panel to be known as the Health Care Panel to De-  
 15 vise a Uniform Explanation of Benefits (in this sec-  
 16 tion referred to as the “Panel”).

17 (2) DUTIES OF PANEL.—

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

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

25 (3) MEMBERSHIP.—

1 (A) SIZE AND COMPOSITION.—The Sec-  
2 retary of Health and Human Services shall de-  
3 termine the number of members and the com-  
4 position of the Panel. Such Panel shall include  
5 equal numbers of representatives of private in-  
6 surance organizations, consumer groups, State  
7 insurance commissioners, State medical soci-  
8 eties, State hospital associations, and State  
9 medical specialty societies.

10 (B) TERMS OF APPOINTMENT.—The mem-  
11 bers of the Panel shall serve for the life of the  
12 Panel.

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

19 (4) PROCEDURES.—

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

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

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

3 (D) HEARINGS.—For the purpose of car-  
4 rying out its duties, the Panel may hold such  
5 hearings and undertake such other activities as  
6 the Panel determines to be necessary to carry  
7 out its duties.

8 (5) ADMINISTRATION.—

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

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

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

24 (D) USE OF MAILS.—The Panel may use  
25 the United States mails in the same manner

1 and under the same conditions as Federal agen-  
2 cies and shall, for purposes of the frank, be  
3 considered a commission of Congress as de-  
4 scribed in section 3215 of title 39, United  
5 States Code.

6 (E) ADMINISTRATIVE SUPPORT SERV-  
7 ICES.—Upon the request of the Panel, the Sec-  
8 retary of Health and Human Services shall pro-  
9 vide to the Panel on a reimbursable basis such  
10 administrative support services as the Panel  
11 may request.

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

16 (7) TERMINATION.—The Panel shall terminate  
17 on the day after submitting the form under para-  
18 graph (6).

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

1 **SEC. 602. NO IMPACT ON SOCIAL SECURITY TRUST FUND.**

2 (a) IN GENERAL.—Nothing in this Act (or an amend-  
3 ment made by this Act) shall be construed to alter or  
4 amend the Social Security Act (or any regulation promul-  
5 gated under that Act).

6 (b) TRANSFERS.—

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

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

**Calendar No. 809**

106TH CONGRESS  
2D SESSION

**S. 3058**

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**A BILL**

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

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SEPTEMBER 18, 2000

Read the second time and placed on the calendar