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To protect consumers in managed care plans and other health coverage, to provide for parity with respect to mental health coverage, to reduce medical errors, and to increase the access of individuals to quality health care.

IN THE SENATE OF THE UNITED STATES

JANUARY 7, 2003

Mr. DASCHLE (for himself, Mr. KENNEDY, Ms. STABENOW, Mrs. CLINTON, Mr. SCHUMER, Mrs. MURRAY, Mr. CORZINE, Mr. DURBIN, Mr. LIEBERMAN, Ms. MIKULSKI, Mr. LEVIN, Mr. ROCKEFELLER, Mr. AKAKA, Mr. JOHNSON, Mr. SARBANES, Mr. DAYTON, Mr. LAUTENBERG, Mr. LEAHY, Mr. REID, and Mr. PRYOR) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To protect consumers in managed care plans and other health coverage, to provide for parity with respect to mental health coverage, to reduce medical errors, and to increase the access of individuals to quality health care.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 "Health Care Coverage Expansion and Quality Improve-
4 ment Act of 2003".

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

Sec. 1. Short title; table of contents.

TITLE I—PATIENT PROTECTIONS

Sec. 101. Short title.

Subtitle A—Improving Managed Care

CHAPTER 1—UTILIZATION REVIEW; CLAIMS; AND INTERNAL AND EXTERNAL APPEALS

Sec. 111. Utilization review activities.
Sec. 112. Procedures for initial claims for benefits and prior authorization determinations.
Sec. 113. Internal appeals of claims denials.
Sec. 114. Independent external appeals procedures.
Sec. 115. Health care consumer assistance fund.

CHAPTER 2—ACCESS TO CARE

Sec. 121. Consumer choice option.
Sec. 122. Choice of health care professional.
Sec. 123. Access to emergency care.
Sec. 124. Timely access to specialists.
Sec. 125. Patient access to obstetrical and gynecological care.
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Sec. 130. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.

CHAPTER 3—ACCESS TO INFORMATION

Sec. 131. Patient access to information.

CHAPTER 4—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

Sec. 141. Prohibition of interference with certain medical communications.
Sec. 142. Prohibition of discrimination against providers based on licensure.
Sec. 143. Prohibition against improper incentive arrangements.
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Sec. 145. Protection for patient advocacy.

CHAPTER 5—DEFINITIONS

Sec. 151. Definitions.
Sec. 152. Preemption; State flexibility; construction.
Sec. 153. Exclusions.
Sec. 154. Treatment of excepted benefits.
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Sec. 156. Incorporation into plan or coverage documents.
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Subtitle B—Application of Quality Care Standards to Group Health Plans and Health Insurance Coverage Under the Public Health Service Act

Sec. 161. Application to group health plans and group health insurance coverage.
Sec. 162. Application to individual health insurance coverage.
Sec. 163. Cooperation between Federal and State authorities.

Subtitle C—Amendments to the Employee Retirement Income Security Act of 1974

Sec. 171. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 172. Availability of civil remedies.
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Sec. 174. Limitations on actions.
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Sec. 176. Sense of the Senate concerning the importance of certain unpaid services.

Subtitle D—Effective Dates; Coordination in Implementation

Sec. 181. Effective dates.
Sec. 182. Coordination in implementation.
Sec. 183. Severability.

Subtitle E—Miscellaneous Provisions

Sec. 191. No impact on Social Security Trust Fund.
Sec. 192. Customs user fees.
Sec. 193. Fiscal year 2003 medicare payments.
Sec. 194. Sense of Senate with respect to participation in clinical trials and access to specialty care.
Sec. 195. Sense of the Senate regarding fair review process.
Sec. 196. Annual review.

TITLE II—MENTAL HEALTH PARITY

Sec. 201. Short title.
Sec. 202. Amendment to the Employee Retirement Income Security Act of 1974.
Sec. 203. Amendment to the Public Health Service Act relating to the group market.
Sec. 204. Preemption.
Sec. 205. General accounting office study.

TITLE III—PATIENT SAFETY

Sec. 301. Short title.
Sec. 302. Purpose.
Sec. 303. Patient safety improvements.
Sec. 304. Required use of product identification technology.

TITLE IV—TAX CREDIT FOR OFFERING EMPLOYER-BASED HEALTH INSURANCE COVERAGE

Sec. 401. Credit for employee health insurance expenses.

TITLE V—FAMILYCARE

Sec. 501. Renaming of title XXI program.
Sec. 502. Familycare coverage of parents and pregnant women under the medicaid program and title XXI.
Sec. 503. Automatic enrollment of children born to title XXI parents.
Sec. 504. Optional coverage of legal immigrants under the medicaid program and title XXI.
Sec. 505. Optional coverage of children through age 20 under the medicaid program and title XXI.
Sec. 506. Application of simplified title XXI procedures under the medicaid program.
Sec. 507. Improving welfare-to-work transition under the medicaid program.
Sec. 508. Elimination of 100 hour rule and other AFDC-related eligibility restrictions.
Sec. 509. Increased Federal reimbursement for language services under the medicaid program and title XXI.
Sec. 510. Limitations on conflicts of interest.
Sec. 511. Title XXI funding.
Sec. 512. Changes to rules for redistribution and extended availability of title XXI fiscal year 2000 and subsequent fiscal year allotments.
Sec. 513. Demonstration programs to improve medicaid and title XXI outreach to homeless individuals and families.
Sec. 514. Technical and conforming amendments to authority to pay medicaid expansion costs from title XXI appropriation.
Sec. 515. Additional title XXI revisions.

TITLE VI—FAMILY OPPORTUNITY

Sec. 601. Opportunity for families of disabled children to purchase medicaid coverage for such children.
Sec. 602. Treatment of inpatient psychiatric hospital services for individuals under age 21 in home or community-based services waivers.
Sec. 603. Development and support of family-to-family health information centers.
Sec. 604. Restoration of medicaid eligibility for certain SSI beneficiaries.

TITLE VII—TEMPORARY STATE FISCAL RELIEF

Sec. 701. Temporary State fiscal relief.

TITLE VIII—IMPROVEMENT OF THE PROCESS FOR THE DEVELOPMENT AND IMPLEMENTATION OF MEDICAID AND SCHIP WAIVERS

Sec. 801. Improvement of the process for the development and implementation of medicaid and SCHIP waivers.

TITLE IX—INDIAN HEALTH CARE FUNDING

Sec. 901. Guaranteed adequate funding for Indian health care.

TITLE I—PATIENT PROTECTIONS

SEC. 101. SHORT TITLE.

This title may be cited as the ''Bipartisan Patient Protection Act''.

Subtitle A—Improving Managed Care

CHAPTER 1—UTILIZATION REVIEW; CLAIMS; AND INTERNAL AND EXTERNAL APPEALS

SEC. 111. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 112.

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

are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed spe-

cifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

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

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

(c) CONDUCT OF PROGRAM ACTIVITIES.—

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

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

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

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

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

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator,

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

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

SEC. 112. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan

or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits, and of the right of the participant, beneficiary, or enrollee to an internal appeal under section 113.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not

later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of subsection (b)(1), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, bene-

ficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claim for such benefits without regard to whether and when a written confirmation of such request is made.

(b) TIMELINE FOR MAKING DETERMINATIONS.—

(1) PRIOR AUTHORIZATION DETERMINATION.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization and in no case later than 28 days after the date of the claim for benefits is received.

1 (B) EXPEDITED DETERMINATION.—Not-
2 withstanding subparagraph (A), a group health
3 plan, and a health insurance issuer offering
4 health insurance coverage, shall expedite a prior
5 authorization determination on a claim for ben-
6 efits described in such subparagraph when a re-
7 quest for such an expedited determination is
8 made by a participant, beneficiary, or enrollee
9 (or authorized representative) at any time dur-
10 ing the process for making a determination and
11 a health care professional certifies, with the re-
12 quest, that a determination under the proce-
13 dures described in subparagraph (A) would seri-
14 ously jeopardize the life or health of the partici-
15 pant, beneficiary, or enrollee or the ability of
16 the participant, beneficiary, or enrollee to main-
17 tain or regain maximum function. Such deter-
18 mination shall be made in accordance with the
19 medical exigencies of the case and as soon as
20 possible, but in no case later than 72 hours
21 after the time the request is received by the
22 plan or issuer under this subparagraph.
23 (C) ONGOING CARE.—
24 (i) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an appeal under section 113(b)(3) to be completed before the termination or reduction takes effect.

(II) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as

well as a statement of the individual's rights to further appeal.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) RETROSPECTIVE DETERMINATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the deter-

1 mination (or, in the case described in subparagraph (B)
2 or (C) of subsection (b)(1), within the 72-hour or applica-
3 ble period referred to in such subparagraph).

4 (d) REQUIREMENTS OF NOTICE OF DETERMINA-
5 TIONS.—The written notice of a denial of a claim for bene-
6 fits determination under subsection (c) shall be provided
7 in printed form and written in a manner calculated to be
8 understood by the participant, beneficiary, or enrollee and
9 shall include—

10 (1) the specific reasons for the determination
11 (including a summary of the clinical or scientific evi-
12 dence used in making the determination);

13 (2) the procedures for obtaining additional in-
14 formation concerning the determination; and

15 (3) notification of the right to appeal the deter-
16 mination and instructions on how to initiate an ap-
17 peal in accordance with section 113.

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

19 (1) AUTHORIZED REPRESENTATIVE.—The term
20 ''authorized representative'' means, with respect to
21 an individual who is a participant, beneficiary, or en-
22 rollee, any health care professional or other person
23 acting on behalf of the individual with the individ-
24 ual's consent or without such consent if the indi-
25 vidual is medically unable to provide such consent.

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

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

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

SEC. 113. INTERNAL APPEALS OF CLAIMS DENIALS.

(a) RIGHT TO INTERNAL APPEAL.—

(1) IN GENERAL.—A participant, beneficiary, or enrollee (or authorized representative) may appeal

any denial of a claim for benefits under section 112 under the procedures described in this section.

(2) TIME FOR APPEAL.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall ensure that a participant, beneficiary, or enrollee (or authorized representative) has a period of not less than 180 days beginning on the date of a denial of a claim for benefits under section 112 in which to appeal such denial under this section.

(B) DATE OF DENIAL.—For purposes of subparagraph (A), the date of the denial shall be deemed to be the date as of which the participant, beneficiary, or enrollee knew of the denial of the claim for benefits.

(3) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination on a claim for benefits under section 112 within the applicable timeline established for such a determination under such section is a denial of a claim for benefits for purposes this chapter as of the date of the applicable deadline.

(4) PLAN WAIVER OF INTERNAL REVIEW.—A group health plan, or health insurance issuer offering health insurance coverage, may waive the inter-

nal review process under this section. In such case the plan or issuer shall provide notice to the participant, beneficiary, or enrollee (or authorized representative) involved, the participant, beneficiary, or enrollee (or authorized representative) involved shall be relieved of any obligation to complete the internal review involved, and may, at the option of such participant, beneficiary, enrollee, or representative proceed directly to seek further appeal through external review under section 114 or otherwise.

(b) TIMELINES FOR MAKING DETERMINATIONS.—

(1) ORAL REQUESTS.—In the case of an appeal of a denial of a claim for benefits under this section that involves an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may request such appeal orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for an appeal of a denial, the making of the request (and the timing of such request) shall be treated as the making at that time

of a request for an appeal without regard to whether and when a written confirmation of such request is made.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an appeal of a denial of a claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the appeal. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of paragraph (3), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with

the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) PRIOR AUTHORIZATION DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in this paragraph or paragraph (4), a group health plan, and a health insurance issuer offering health insurance coverage, shall make a determination on an appeal of a denial of a claim for benefits under this subsection in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 28 days after the date the request for the appeal is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, and a health insurance issuer offering

1 health insurance coverage, shall expedite a prior
2 authorization determination on an appeal of a
3 denial of a claim for benefits described in sub-
4 paragraph (A), when a request for such an ex-
5 pedited determination is made by a participant,
6 beneficiary, or enrollee (or authorized represent-
7 ative) at any time during the process for mak-
8 ing a determination and a health care profes-
9 sional certifies, with the request, that a deter-
10 mination under the procedures described in sub-
11 paragraph (A) would seriously jeopardize the
12 life or health of the participant, beneficiary, or
13 enrollee or the ability of the participant, bene-
14 ficiary, or enrollee to maintain or regain max-
15 imum function. Such determination shall be
16 made in accordance with the medical exigencies
17 of the case and as soon as possible, but in no
18 case later than 72 hours after the time the re-
19 quest for such appeal is received by the plan
20 or issuer under this subparagraph.
21 (C) ONGOING CARE DETERMINATIONS.—
22 (i) IN GENERAL.—Subject to clause
23 (ii), in the case of a concurrent review de-
24 termination described in section
25 112(b)(1)(C)(i)(I), which results in a ter-

mination or reduction of such care, the plan or issuer must provide notice of the determination on the appeal under this section by telephone and in printed form to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an external appeal under section 114 to be completed before the termination or reduction takes effect.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(4) RETROSPECTIVE DETERMINATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a denial of a claim for benefits in no case later than 30 days after the date on which the plan or issuer receives necessary information that is reasonably necessary to enable the plan or issuer to make a determination on

the appeal and in no case later than 60 days after the date the request for the appeal is received.

(c) CONDUCT OF REVIEW.—

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

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

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

(B) in a claim for benefits provided by a non-physician health professional, shall be made by reviewer (or reviewers) including at least one practicing non-physician health professional of the same or similar specialty;

with appropriate expertise (including, in the case of a child, appropriate pediatric expertise) and acting within the appropriate scope of practice within the State in which the service is provided or rendered, who was not involved in the initial determination.

1 (d) NOTICE OF DETERMINATION.—

2 (1) IN GENERAL.—Written notice of a deter-
3 mination made under an internal appeal of a denial
4 of a claim for benefits shall be issued to the partici-
5 pant, beneficiary, or enrollee (or authorized rep-
6 resentative) and the treating health care professional
7 in accordance with the medical exigencies of the case
8 and as soon as possible, but in no case later than
9 2 days after the date of completion of the review (or,
10 in the case described in subparagraph (B) or (C) of
11 subsection (b)(3), within the 72-hour or applicable
12 period referred to in such subparagraph).

13 (2) FINAL DETERMINATION.—The decision by a
14 plan or issuer under this section shall be treated as
15 the final determination of the plan or issuer on a de-
16 nial of a claim for benefits. The failure of a plan or
17 issuer to issue a determination on an appeal of a de-
18 nial of a claim for benefits under this section within
19 the applicable timeline established for such a deter-
20 mination shall be treated as a final determination on
21 an appeal of a denial of a claim for benefits for pur-
22 poses of proceeding to external review under section
23 114.

24 (3) REQUIREMENTS OF NOTICE.—With respect
25 to a determination made under this section, the no-

tice described in paragraph (1) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the determination; and

(C) notification of the right to an independent external review under section 114 and instructions on how to initiate such a review.

SEC. 114. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide in accordance with this section participants, beneficiaries, and enrollees (or authorized representatives) with access to an independent external review for any denial of a claim for benefits.

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

(1) TIME TO FILE.—A request for an independent external review under this section shall be

filed with the plan or issuer not later than 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the denial under section 113(d) or notice of waiver of internal review under section 113(a)(4) or the date on which the plan or issuer has failed to make a timely decision under section 113(d)(2) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(2) FILING OF REQUEST.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a group health plan, or health insurance issuer offering health insurance coverage, may—

(i) except as provided in subparagraph (B)(i), require that a request for review be in writing;

(ii) limit the filing of such a request to the participant, beneficiary, or enrollee involved (or an authorized representative);

(iii) except if waived by the plan or issuer under section 113(a)(4), condition

access to an independent external review under this section upon a final determination of a denial of a claim for benefits under the internal review procedure under section 113;

(iv) except as provided in subparagraph (B)(ii), require payment of a filing fee to the plan or issuer of a sum that does not exceed $25; and

(v) require that a request for review include the consent of the participant, beneficiary, or enrollee (or authorized representative) for the release of necessary medical information or records of the participant, beneficiary, or enrollee to the qualified external review entity only for purposes of conducting external review activities.

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(i) ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request for such review

may be made orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such a review without regard to whether and when a written confirmation of such request is made.

(ii) EXCEPTION TO FILING FEE REQUIREMENT.—

(I) INDIGENCY.—Payment of a filing fee shall not be required under subparagraph (A)(iv) where there is a certification (in a form and manner specified in guidelines established by the appropriate Secretary) that the

1 participant, beneficiary, or enrollee is
2 indigent (as defined in such guide-
3 lines).
4 (II) FEE NOT REQUIRED.—Pay-
5 ment of a filing fee shall not be re-
6 quired under subparagraph (A)(iv) if
7 the plan or issuer waives the internal
8 appeals process under section
9 113(a)(4).
10 (III) REFUNDING OF FEE.—The
11 filing fee paid under subparagraph
12 (A)(iv) shall be refunded if the deter-
13 mination under the independent exter-
14 nal review is to reverse or modify the
15 denial which is the subject of the re-
16 view.
17 (IV) COLLECTION OF FILING
18 FEE.—The failure to pay such a filing
19 fee shall not prevent the consideration
20 of a request for review but, subject to
21 the preceding provisions of this clause,
22 shall constitute a legal liability to pay.
23 (c) REFERRAL TO QUALIFIED EXTERNAL REVIEW
24 ENTITY UPON REQUEST.—

(1) IN GENERAL.—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering health insurance coverage, the plan or issuer shall immediately refer such request, and forward the plan or issuer's initial decision (including the information described in section 113(d)(3)(A)), to a qualified external review entity selected in accordance with this section.

(2) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant, beneficiary, or enrollee (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with information that is necessary to conduct a review under this section, as determined and requested by the entity. Such information shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in clause (ii) or (iii) of subsection (e)(1)(A), by such earlier time as may be necessary to comply with the applicable timeline under such clause.

(3) SCREENING OF REQUESTS BY QUALIFIED EXTERNAL REVIEW ENTITIES.—

(A) IN GENERAL.—With respect to a request referred to a qualified external review entity under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless the entity determines that—

(i) any of the conditions described in clauses (ii) or (iii) of subsection (b)(2)(A) have not been met;

(ii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

(iii) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant, beneficiary, or enrollee who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

(iv) the denial of the claim for benefits is a decision as to the application of cost-sharing requirements or the application of a specific exclusion or express limi-

tation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage unless the decision is a denial described in subsection (d)(2).

Upon making a determination that any of clauses (i) through (iv) applies with respect to the request, the entity shall determine that the denial of a claim for benefits involved is not eligible for independent medical review under subsection (d), and shall provide notice in accordance with subparagraph (C).

(B) PROCESS FOR MAKING DETERMINATIONS.—

(i) NO DEFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no deference given to determinations made by the plan or issuer or the recommendation of a treating health care professional (if any).

(ii) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified per-

1 sonnel to make determinations under this
2 section.
3 (C) NOTICES AND GENERAL TIMELINES
4 FOR DETERMINATION.—
5 (i) NOTICE IN CASE OF DENIAL OF
6 REFERRAL.—If the entity under this para-
7 graph does not make a referral to an inde-
8 pendent medical reviewer, the entity shall
9 provide notice to the plan or issuer, the
10 participant, beneficiary, or enrollee (or au-
11 thorized representative) filing the request,
12 and the treating health care professional
13 (if any) that the denial is not subject to
14 independent medical review. Such notice—
15 (I) shall be written (and, in addi-
16 tion, may be provided orally) in a
17 manner calculated to be understood
18 by a participant or enrollee;
19 (II) shall include the reasons for
20 the determination;
21 (III) include any relevant terms
22 and conditions of the plan or cov-
23 erage; and

(IV) include a description of any further recourse available to the individual.

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

(d) INDEPENDENT MEDICAL REVIEW.—

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

conduct of an independent medical review under this subsection.

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

(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—A determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—A determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms.

(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an

evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(A) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to whether or not the denial of a claim for a benefit that is the subject of the review should be upheld, reversed, or modified.

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

1 (C) NO COVERAGE FOR EXCLUDED BENE-
2 FITS.—Nothing in this subsection shall be con-
3 strued to permit an independent medical re-
4 viewer to require that a group health plan, or
5 health insurance issuer offering health insur-
6 ance coverage, provide coverage for items or
7 services for which benefits are specifically ex-
8 cluded or expressly limited under the plan or
9 coverage in the plain language of the plan docu-
10 ment (and which are disclosed under section
11 131(b)(1)(C)). Notwithstanding any other pro-
12 vision of this title, any exclusion of an exact
13 medical procedure, any exact time limit on the
14 duration or frequency of coverage, and any
15 exact dollar limit on the amount of coverage
16 that is specifically enumerated and defined (in
17 the plain language of the plan or coverage docu-
18 ments) under the plan or coverage offered by a
19 group health plan or health insurance issuer of-
20 fering health insurance coverage and that is
21 disclosed under section 131(b)(1) shall be con-
22 sidered to govern the scope of the benefits that
23 may be required: *Provided,* That the terms and
24 conditions of the plan or coverage relating to

1 such an exclusion or limit are in compliance
2 with the requirements of law.
3 (D) EVIDENCE AND INFORMATION TO BE
4 USED IN MEDICAL REVIEWS.—In making a de-
5 termination under this subsection, the inde-
6 pendent medical reviewer shall also consider ap-
7 propriate and available evidence and informa-
8 tion, including the following:
9 (i) The determination made by the
10 plan or issuer with respect to the claim
11 upon internal review and the evidence,
12 guidelines, or rationale used by the plan or
13 issuer in reaching such determination.
14 (ii) The recommendation of the treat-
15 ing health care professional and the evi-
16 dence, guidelines, and rationale used by
17 the treating health care professional in
18 reaching such recommendation.
19 (iii) Additional relevant evidence or
20 information obtained by the reviewer or
21 submitted by the plan, issuer, participant,
22 beneficiary, or enrollee (or an authorized
23 representative), or treating health care
24 professional.
25 (iv) The plan or coverage document.

(E) INDEPENDENT DETERMINATION.—In making determinations under this section, a qualified external review entity and an independent medical reviewer shall—

(i) consider the claim under review without deference to the determinations made by the plan or issuer or the recommendation of the treating health care professional (if any); and

(ii) consider, but not be bound by, the definition used by the plan or issuer of ''medically necessary and appropriate'', or ''experimental or investigational'', or other substantially equivalent terms that are used by the plan or issuer to describe medical necessity and appropriateness or experimental or investigational nature of the treatment.

(F) DETERMINATION OF INDEPENDENT MEDICAL REVIEWER.—An independent medical reviewer shall, in accordance with the deadlines described in subsection (e), prepare a written determination to uphold, reverse, or modify the denial under review. Such written determination shall include—

(i) the determination of the reviewer;

(ii) the specific reasons of the reviewer for such determination, including a summary of the clinical or scientific evidence used in making the determination; and

(iii) with respect to a determination to reverse or modify the denial under review, a timeframe within which the plan or issuer must comply with such determination.

(G) NONBINDING NATURE OF ADDITIONAL RECOMMENDATIONS.—In addition to the determination under subparagraph (F), the reviewer may provide the plan or issuer and the treating health care professional with additional recommendations in connection with such a determination, but any such recommendations shall not affect (or be treated as part of) the determination and shall not be binding on the plan or issuer.

(e) TIMELINES AND NOTIFICATIONS.—

(1) TIMELINES FOR INDEPENDENT MEDICAL REVIEW.—

1 (A) PRIOR AUTHORIZATION DETERMINA-
2 TION.—
3 (i) IN GENERAL.—The independent
4 medical reviewer (or reviewers) shall make
5 a determination on a denial of a claim for
6 benefits that is referred to the reviewer
7 under subsection (c)(3) in accordance with
8 the medical exigencies of the case and as
9 soon as possible, but in no case later than
10 14 days after the date of receipt of infor-
11 mation under subsection (c)(2) if the re-
12 view involves a prior authorization of items
13 or services and in no case later than 21
14 days after the date the request for external
15 review is received.
16 (ii) EXPEDITED DETERMINATION.—
17 Notwithstanding clause (i) and subject to
18 clause (iii), the independent medical re-
19 viewer (or reviewers) shall make an expe-
20 dited determination on a denial of a claim
21 for benefits described in clause (i), when a
22 request for such an expedited determina-
23 tion is made by a participant, beneficiary,
24 or enrollee (or authorized representative)
25 at any time during the process for making

a determination, and a health care professional certifies, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for external review is received by the qualified external review entity.

(iii) ONGOING CARE DETERMINATION.—Notwithstanding clause (i), in the case of a review described in such clause that involves a termination or reduction of care, the notice of the determination shall be completed not later than 24 hours after the time the request for external review is received by the qualified external review entity and before the end of the approved period of care.

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

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) receives a copy of the written determination of the independent medical reviewer prepared under subsection (d)(3)(F). Nothing in this paragraph shall be construed as preventing an entity or reviewer from providing an initial oral notice of the reviewer's determination.

(3) FORM OF NOTICES.—Determinations and notices under this subsection shall be written in a manner calculated to be understood by a participant.

(f) COMPLIANCE.—

1 (1) APPLICATION OF DETERMINATIONS.—

2 (A) EXTERNAL REVIEW DETERMINATIONS
3 BINDING ON PLAN.—The determinations of an
4 external review entity and an independent med-
5 ical reviewer under this section shall be binding
6 upon the plan or issuer involved.

7 (B) COMPLIANCE WITH DETERMINA-
8 TION.—If the determination of an independent
9 medical reviewer is to reverse or modify the de-
10 nial, the plan or issuer, upon the receipt of such
11 determination, shall authorize coverage to com-
12 ply with the medical reviewer's determination in
13 accordance with the timeframe established by
14 the medical reviewer.

15 (2) FAILURE TO COMPLY.—

16 (A) IN GENERAL.—If a plan or issuer fails
17 to comply with the timeframe established under
18 paragraph (1)(B) with respect to a participant,
19 beneficiary, or enrollee, where such failure to
20 comply is caused by the plan or issuer, the par-
21 ticipant, beneficiary, or enrollee may obtain the
22 items or services involved (in a manner con-
23 sistent with the determination of the inde-
24 pendent external reviewer) from any provider

1 regardless of whether such provider is a partici-
2 pating provider under the plan or coverage.
3 (B) REIMBURSEMENT.—
4 (i) IN GENERAL.—Where a partici-
5 pant, beneficiary, or enrollee obtains items
6 or services in accordance with subpara-
7 graph (A), the plan or issuer involved shall
8 provide for reimbursement of the costs of
9 such items or services. Such reimburse-
10 ment shall be made to the treating health
11 care professional or to the participant, ben-
12 eficiary, or enrollee (in the case of a partic-
13 ipant, beneficiary, or enrollee who pays for
14 the costs of such items or services).
15 (ii) AMOUNT.—The plan or issuer
16 shall fully reimburse a professional, partici-
17 pant, beneficiary, or enrollee under clause
18 (i) for the total costs of the items or serv-
19 ices provided (regardless of any plan limi-
20 tations that may apply to the coverage of
21 such items or services) so long as the items
22 or services were provided in a manner con-
23 sistent with the determination of the inde-
24 pendent medical reviewer.

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

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

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

(A) MONETARY PENALTIES.—

(i) IN GENERAL.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of au-

1 thorizing the benefit, causes such refusal
2 may, in the discretion of a court of com-
3 petent jurisdiction, be liable to an ag-
4 grieved participant, beneficiary, or enrollee
5 for a civil penalty in an amount of up to
6 $1,000 a day from the date on which the
7 determination was transmitted to the plan
8 or issuer by the external review entity until
9 the date the refusal to provide the benefit
10 is corrected.

11 (ii) ADDITIONAL PENALTY FOR FAIL-
12 ING TO FOLLOW TIMELINE.—In any case
13 in which treatment was not commenced by
14 the plan in accordance with the determina-
15 tion of an independent external reviewer,
16 the Secretary shall assess a civil penalty of
17 $10,000 against the plan and the plan
18 shall pay such penalty to the participant,
19 beneficiary, or enrollee involved.

20 (B) CEASE AND DESIST ORDER AND
21 ORDER OF ATTORNEY'S FEES.—In any action
22 described in subparagraph (A) brought by a
23 participant, beneficiary, or enrollee with respect
24 to a group health plan, or a health insurance
25 issuer offering health insurance coverage, in

which a plaintiff alleges that a person referred to in such subparagraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity to be covered, or has failed to take an action for which such person is responsible under the terms and conditions of the plan or coverage and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

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

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

(C) ADDITIONAL CIVIL PENALTIES.—

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

1 insurance issuers offering health insurance
2 coverage, for—
3 (I) any pattern or practice of re-
4 peated refusal to authorize a benefit
5 determined by an external appeal enti-
6 ty to be covered; or
7 (II) any pattern or practice of re-
8 peated violations of the requirements
9 of this section with respect to such
10 plan or coverage.
11 (ii) STANDARD OF PROOF AND
12 AMOUNT OF PENALTY.—Such penalty shall
13 be payable only upon proof by clear and
14 convincing evidence of such pattern or
15 practice and shall be in an amount not to
16 exceed the lesser of—
17 (I) 25 percent of the aggregate
18 value of benefits shown by the appro-
19 priate Secretary to have not been pro-
20 vided, or unlawfully delayed, in viola-
21 tion of this section under such pattern
22 or practice; or
23 (II) $500,000.
24 (D) REMOVAL AND DISQUALIFICATION.—
25 Any person acting in the capacity of author-

1 izing benefits who has engaged in any such pat-
2 tern or practice described in subparagraph
3 (C)(i) with respect to a plan or coverage, upon
4 the petition of the appropriate Secretary, may
5 be removed by the court from such position,
6 and from any other involvement, with respect to
7 such a plan or coverage, and may be precluded
8 from returning to any such position or involve-
9 ment for a period determined by the court.
10 (4) PROTECTION OF LEGAL RIGHTS.—Nothing
11 in this subsection or chapter shall be construed as
12 altering or eliminating any cause of action or legal
13 rights or remedies of participants, beneficiaries, en-
14 rollees, and others under State or Federal law (in-
15 cluding sections 502 and 503 of the Employee Re-
16 tirement Income Security Act of 1974), including
17 the right to file judicial actions to enforce rights.
18 (g) QUALIFICATIONS OF INDEPENDENT MEDICAL
19 REVIEWERS.—
20 (1) IN GENERAL.—In referring a denial to 1 or
21 more individuals to conduct independent medical re-
22 view under subsection (c), the qualified external re-
23 view entity shall ensure that—

(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

(B) with respect to each review at least 1 such reviewer meets the requirements described in paragraphs (4) and (5); and

(C) compensation provided by the entity to the reviewer is consistent with paragraph (6).

(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(3) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

(i) not be a related party (as defined in paragraph (7));

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

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

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

(i) prohibit an individual, solely on the basis of affiliation with the plan or issuer, from serving as an independent medical reviewer if—

(I) a non-affiliated individual is not reasonably available;

(II) the affiliated individual is not involved in the provision of items or services in the case under review;

(III) the fact of such an affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative) and neither party objects; and

(IV) the affiliated individual is not an employee of the plan or issuer and does not provide services exclu-

sively or primarily to or on behalf of the plan or issuer;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in

which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

(ii) by a non-physician health care professional, a reviewer (or reviewers) shall include at least one practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(B) PRACTICING DEFINED.—For purposes of this paragraph, the term ''practicing'' means, with respect to an individual who is a physician or other health care professional that the individual provides health care services to individual patients on average at least 2 days per week.

(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified external review entity to an independent medical reviewer in connection with a review under this section shall—

(A) not exceed a reasonable level; and

(B) not be contingent on the decision rendered by the reviewer.

(7) RELATED PARTY DEFINED.—For purposes of this section, the term ''related party'' means, with respect to a denial of a claim under a plan or coverage relating to a participant, beneficiary, or enrollee, any of the following:

(A) The plan, plan sponsor, or issuer involved, or any fiduciary, officer, director, or employee of such plan, plan sponsor, or issuer.

(B) The participant, beneficiary, or enrollee (or authorized representative).

(C) The health care professional that provides the items or services involved in the denial.

(D) The institution at which the items or services (or treatment) involved in the denial are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

(1) SELECTION OF QUALIFIED EXTERNAL REVIEW ENTITIES.—

(A) LIMITATION ON PLAN OR ISSUER SELECTION.—The appropriate Secretary shall implement procedures—

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

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

No such selection process under the procedures implemented by the appropriate Secretary may give either the patient or the plan or issuer any ability to determine or influence the selection of

a qualified external review entity to review the case of any participant, beneficiary, or enrollee.

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

(2) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).

(3) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—

(A) be consistent with the standards the appropriate Secretary shall establish to assure

there is no real or apparent conflict of interest in the conduct of external review activities; and

(B) provide that the costs of the external review process shall be borne by the plan or issuer.

Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(iv) or costs incurred by the participant, beneficiary, or enrollee (or authorized representative) or treating health care professional (if any) in support of the review, including the provision of additional evidence or information.

(4) QUALIFICATIONS.—

(A) IN GENERAL.—In this section, the term ''qualified external review entity'' means, in relation to a plan or issuer, an entity that is initially certified (and periodically recertified) under subparagraph (C) as meeting the following requirements:

(i) The entity has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to carry out duties of a qualified external review entity under this section on a timely basis, including making

determinations under subsection (b)(2)(A) and providing for independent medical reviews under subsection (d).

(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or subsidiary of a professional or trade association of plans or issuers or of health care providers.

(iii) The entity has provided assurances that it will conduct external review activities consistent with the applicable requirements of this section and standards specified in subparagraph (C), including that it will not conduct any external review activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).

(v) The entity meets such other requirements as the appropriate Secretary provides by regulation.

(B) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—

(I) is not a related party (as defined in subsection (g)(7));

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

(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified external review entity of compensation from a plan or issuer for the conduct of external review activities under this section if the compensation is provided consistent with clause (iii).

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—

(I) not exceed a reasonable level; and

(II) not be contingent on any decision rendered by the entity or by any independent medical reviewer.

(C) CERTIFICATION AND RECERTIFICATION PROCESS.—

(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—

(I) under a process that is recognized or approved by the appropriate Secretary; or

(II) by a qualified private standard-setting organization that is approved by the appropriate Secretary under clause (iii).

In taking action under subclause (I), the appropriate Secretary shall give deference to entities that are under contract with the Federal Government or with an applicable State authority to perform functions of the type performed by qualified external review entities.

1 (ii) PROCESS.—The appropriate Sec-
2 retary shall not recognize or approve a
3 process under clause (i)(I) unless the proc-
4 ess applies standards (as promulgated in
5 regulations) that ensure that a qualified
6 external review entity—
7 (I) will carry out (and has car-
8 ried out, in the case of recertification)
9 the responsibilities of such an entity
10 in accordance with this section, in-
11 cluding meeting applicable deadlines;
12 (II) will meet (and has met, in
13 the case of recertification) appropriate
14 indicators of fiscal integrity;
15 (III) will maintain (and has
16 maintained, in the case of recertifi-
17 cation) appropriate confidentiality
18 with respect to individually identifi-
19 able health information obtained in
20 the course of conducting external re-
21 view activities; and
22 (IV) in the case of recertification,
23 shall review the matters described in
24 clause (iv).

(iii) APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of clause (i)(II), the appropriate Secretary may approve a qualified private standard-setting organization if such Secretary finds that the organization only certifies (or recertifies) external review entities that meet at least the standards required for the certification (or recertification) of external review entities under clause (ii).

(iv) CONSIDERATIONS IN RECERTIFICATIONS.—In conducting recertifications of a qualified external review entity under this paragraph, the appropriate Secretary or organization conducting the recertification shall review compliance of the entity with the requirements for conducting external review activities under this section, including the following:

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

(II) Adherence to applicable deadlines (both by the entity and by

independent medical reviewers it refers cases to).

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

(IV) Compliance with applicable independence requirements.

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—A certification or recertification provided under this paragraph shall extend for a period not to exceed 2 years.

(vi) REVOCATION.—A certification or recertification under this paragraph may be revoked by the appropriate Secretary or

by the organization providing such certification upon a showing of cause. The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

(viii) SUFFICIENT NUMBER OF ENTITIES.—The appropriate Secretary shall certify and recertify a number of external review entities which is sufficient to ensure the timely and efficient provision of review services.

(D) PROVISION OF INFORMATION.—

(i) IN GENERAL.—A qualified external review entity shall provide to the appropriate Secretary, in such manner and at such times as such Secretary may require, such information (relating to the denials which have been referred to the entity for the conduct of external review under this section) as such Secretary determines appropriate to assure compliance with the independence and other requirements of this section to monitor and assess the quality of its external review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

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

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

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

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

(IV) Updated information on the information required to be submitted as a condition of certification with respect to the entity's performance of external review activities.

(iii) INFORMATION TO BE PROVIDED TO CERTIFYING ORGANIZATION.—

(I) IN GENERAL.—In the case of a qualified external review entity which is certified (or recertified) under this subsection by a qualified private standard-setting organization, at the request of the organization, the entity shall provide the organization

with the information provided to the appropriate Secretary under clause (i).

(II) ADDITIONAL INFORMATION.—Nothing in this subparagraph shall be construed as preventing such an organization from requiring additional information as a condition of certification or recertification of an entity.

(iv) USE OF INFORMATION.—Information provided under this subparagraph may be used by the appropriate Secretary and qualified private standard-setting organizations to conduct oversight of qualified external review entities, including recertification of such entities, and shall be made available to the public in an appropriate manner.

(E) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is employed by any such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held by

reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 181, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

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

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

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

SEC. 115. HEALTH CARE CONSUMER ASSISTANCE FUND.

(a) GRANTS.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 ''Secretary'') shall establish a fund, to be known as
4 the ''Health Care Consumer Assistance Fund'', to be
5 used to award grants to eligible States to carry out
6 consumer assistance activities (including programs
7 established by States prior to the enactment of this
8 Act) designed to provide information, assistance, and
9 referrals to consumers of health insurance products.
10 (2) STATE ELIGIBILITY.—To be eligible to re-
11 ceive a grant under this subsection a State shall pre-
12 pare and submit to the Secretary an application at
13 such time, in such manner, and containing such in-
14 formation as the Secretary may require, including a
15 State plan that describes—
16 (A) the manner in which the State will en-
17 sure that the health care consumer assistance
18 office (established under paragraph (4)) will
19 educate and assist health care consumers in ac-
20 cessing needed care;
21 (B) the manner in which the State will co-
22 ordinate and distinguish the services provided
23 by the health care consumer assistance office
24 with the services provided by Federal, State and
25 local health-related ombudsman, information,

1 protection and advocacy, insurance, and fraud
2 and abuse programs;
3 (C) the manner in which the State will
4 provide information, outreach, and services to
5 underserved, minority populations with limited
6 English proficiency and populations residing in
7 rural areas;
8 (D) the manner in which the State will
9 oversee the health care consumer assistance of-
10 fice, its activities, product materials and evalu-
11 ate program effectiveness;
12 (E) the manner in which the State will en-
13 sure that funds made available under this sec-
14 tion will be used to supplement, and not sup-
15 plant, any other Federal, State, or local funds
16 expended to provide services for programs de-
17 scribed under this section and those described
18 in subparagraphs (C) and (D);
19 (F) the manner in which the State will en-
20 sure that health care consumer office personnel
21 have the professional background and training
22 to carry out the activities of the office; and
23 (G) the manner in which the State will en-
24 sure that consumers have direct access to con-

sumer assistance personnel during regular business hours.

(3) AMOUNT OF GRANT.—

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

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

(C) NON-FEDERAL CONTRIBUTIONS.—A State will provide for the collection of non-Fed-

eral contributions for the operation of the office in an amount that is not less than 25 percent of the amount of Federal funds provided to the State under this section.

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

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

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

(C) EXISTING STATE ENTITY.—Nothing in this section shall prevent the funding of an existing health care consumer assistance program

that otherwise meets the requirements of this section.

(b) USE OF FUNDS.—

(1) BY STATE.—A State shall use amounts provided under a grant awarded under this section to carry out consumer assistance activities directly or by contract with an independent, non-profit organization. An eligible entity may use some reasonable amount of such grant to ensure the adequate training of personnel carrying out such activities. To receive amounts under this subsection, an eligible entity shall provide consumer assistance services, including—

(A) the operation of a toll-free telephone hotline to respond to consumer requests;

(B) the dissemination of appropriate educational materials on available health insurance products and on how best to access health care and the rights and responsibilities of health care consumers;

(C) the provision of education on effective methods to promptly and efficiently resolve questions, problems, and grievances;

(D) the coordination of educational and outreach efforts with health plans, health care providers, payers, and governmental agencies;

(E) referrals to appropriate private and public entities to resolve questions, problems and grievances; and

(F) the provision of information and assistance, including acting as an authorized representative, regarding internal, external, or administrative grievances or appeals procedures in nonlitigative settings to appeal the denial, termination, or reduction of health care services, or the refusal to pay for such services, under a group health plan or health insurance coverage offered by a health insurance issuer.

(2) CONFIDENTIALITY AND ACCESS TO INFORMATION.—

(A) STATE ENTITY.—With respect to a State that directly establishes a health care consumer assistance office, such office shall establish and implement procedures and protocols in accordance with applicable Federal and State laws.

(B) CONTRACT ENTITY.—With respect to a State that, through contract, establishes a

1 health care consumer assistance office, such of-
2 fice shall establish and implement procedures
3 and protocols, consistent with applicable Fed-
4 eral and State laws, to ensure the confiden-
5 tiality of all information shared by a partici-
6 pant, beneficiary, enrollee, or their personal
7 representative and their health care providers,
8 group health plans, or health insurance insurers
9 with the office and to ensure that no such infor-
10 mation is used by the office, or released or dis-
11 closed to State agencies or outside persons or
12 entities without the prior written authorization
13 (in accordance with section 164.508 of title 45,
14 Code of Federal Regulations) of the individual
15 or personal representative. The office may, con-
16 sistent with applicable Federal and State con-
17 fidentiality laws, collect, use or disclose aggre-
18 gate information that is not individually identi-
19 fiable (as defined in section 164.501 of title 45,
20 Code of Federal Regulations). The office shall
21 provide a written description of the policies and
22 procedures of the office with respect to the
23 manner in which health information may be
24 used or disclosed to carry out consumer assist-
25 ance activities. The office shall provide health

care providers, group health plans, or health insurance issuers with a written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) to allow the office to obtain medical information relevant to the matter before the office.

(3) AVAILABILITY OF SERVICES.—The health care consumer assistance office of a State shall not discriminate in the provision of information, referrals, and services regardless of the source of the individual's health insurance coverage or prospective coverage, including individuals covered under a group health plan or health insurance coverage offered by a health insurance issuer, the medicare or medicaid programs under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 and 1396 et seq.), or under any other Federal or State health care program.

(4) DESIGNATION OF RESPONSIBILITIES.—

(A) WITHIN EXISTING STATE ENTITY.—If the health care consumer assistance office of a State is located within an existing State regulatory agency or office of an elected State official, the State shall ensure that—

(i) there is a separate delineation of the funding, activities, and responsibilities of the office as compared to the other funding, activities, and responsibilities of the agency; and

(ii) the office establishes and implements procedures and protocols to ensure the confidentiality of all information shared by a participant, beneficiary, or enrollee or their personal representative and their health care providers, group health plans, or health insurance issuers with the office and to ensure that no information is disclosed to the State agency or office without the written authorization of the individual or their personal representative in accordance with paragraph (2).

(B) CONTRACT ENTITY.—In the case of an entity that enters into a contract with a State under subsection (a)(3), the entity shall provide assurances that the entity has no conflict of interest in carrying out the activities of the office and that the entity is independent of group health plans, health insurance issuers, providers, payers, and regulators of health care.

(5) SUBCONTRACTS.—The health care consumer assistance office of a State may carry out activities and provide services through contracts entered into with 1 or more nonprofit entities so long as the office can demonstrate that all of the requirements of this section are complied with by the office.

(6) TERM.—A contract entered into under this subsection shall be for a term of 3 years.

(c) REPORT.—Not later than 1 year after the Secretary first awards grants under this section, and annually thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the activities funded under this section and the effectiveness of such activities in resolving health care-related problems and grievances.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

CHAPTER 2—ACCESS TO CARE

SEC. 121. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If—

(1) a health insurance issuer providing health insurance coverage in connection with a group health plan offers to enrollees health insurance coverage which provides for coverage of services (including

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

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

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

SEC. 122. CHOICE OF HEALTH CARE PROFESSIONAL.

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

(b) SPECIALISTS.—

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

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

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 124 (relating to access to specialty care).

SEC. 123. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

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

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

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

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

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

1 enue Code of 1986, and other than applicable
2 cost-sharing).
3 (2) DEFINITIONS.—In this section:
4 (A) EMERGENCY MEDICAL CONDITION.—
5 The term ''emergency medical condition'' means
6 a medical condition manifesting itself by acute
7 symptoms of sufficient severity (including se-
8 vere pain) such that a prudent layperson, who
9 possesses an average knowledge of health and
10 medicine, could reasonably expect the absence
11 of immediate medical attention to result in a
12 condition described in clause (i), (ii), or (iii) of
13 section 1867(e)(1)(A) of the Social Security
14 Act.
15 (B) EMERGENCY SERVICES.—The term
16 ''emergency services'' means, with respect to an
17 emergency medical condition—
18 (i) a medical screening examination
19 (as required under section 1867 of the So-
20 cial Security Act) that is within the capa-
21 bility of the emergency department of a
22 hospital, including ancillary services rou-
23 tinely available to the emergency depart-
24 ment to evaluate such emergency medical
25 condition, and

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

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services

(as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 124. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

1 (1) IN GENERAL.—A group health plan and a
2 health insurance issuer offering health insurance
3 coverage shall ensure that participants, beneficiaries,
4 and enrollees receive timely access to specialists who
5 are appropriate to the condition of, and accessible
6 to, the participant, beneficiary, or enrollee, when
7 such specialty care is a covered benefit under the
8 plan or coverage.
9 (2) RULE OF CONSTRUCTION.—Nothing in
10 paragraph (1) shall be construed—
11 (A) to require the coverage under a group
12 health plan or health insurance coverage of ben-
13 efits or services;
14 (B) to prohibit a plan or issuer from in-
15 cluding providers in the network only to the ex-
16 tent necessary to meet the needs of the plan's
17 or issuer's participants, beneficiaries, or enroll-
18 ees; or
19 (C) to override any State licensure or
20 scope-of-practice law.
21 (3) ACCESS TO CERTAIN PROVIDERS.—
22 (A) IN GENERAL.—With respect to spe-
23 cialty care under this section, if a participating
24 specialist is not available and qualified to pro-
25 vide such care to the participant, beneficiary, or

enrollee, the plan or issuer shall provide for coverage of such care by a nonparticipating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) REFERRALS.—

(1) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a nonpartici-

1 pating specialist (described in subsection
2 (a)(3)).
3 (2) REFERRALS FOR ONGOING SPECIAL CONDI-
4 TIONS.—
5 (A) IN GENERAL.—Subject to subsection
6 (a)(1), a group health plan and a health insur-
7 ance issuer shall permit a participant, bene-
8 ficiary, or enrollee who has an ongoing special
9 condition (as defined in subparagraph (B)) to
10 receive a referral to a specialist for the treat-
11 ment of such condition and such specialist may
12 authorize such referrals, procedures, tests, and
13 other medical services with respect to such con-
14 dition, or coordinate the care for such condi-
15 tion, subject to the terms of a treatment plan
16 (if any) referred to in subsection (c) with re-
17 spect to the condition.
18 (B) ONGOING SPECIAL CONDITION DE-
19 FINED.—In this subsection, the term ''ongoing
20 special condition'' means a condition or disease
21 that—
22 (i) is life-threatening, degenerative,
23 potentially disabling, or congenital; and
24 (ii) requires specialized medical care
25 over a prolonged period of time.

1 (c) TREATMENT PLANS.—

2 (1) IN GENERAL.—A group health plan or
3 health insurance issuer may require that the spe-
4 cialty care be provided—

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

7 (i) is developed by the specialist, in
8 consultation with the case manager or pri-
9 mary care provider, and the participant,
10 beneficiary, or enrollee, and

11 (ii) is approved by the plan or issuer
12 in a timely manner, if the plan or issuer
13 requires such approval; and

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

17 (2) NOTIFICATION.—Nothing in paragraph (1)
18 shall be construed as prohibiting a plan or issuer
19 from requiring the specialist to provide the plan or
20 issuer with regular updates on the specialty care
21 provided, as well as all other reasonably necessary
22 medical information.

23 (d) SPECIALIST DEFINED.—For purposes of this sec-
24 tion, the term ''specialist'' means, with respect to the con-
25 dition of the participant, beneficiary, or enrollee, a health

1 care professional, facility, or center that has adequate ex-
2 pertise through appropriate training and experience (in-
3 cluding, in the case of a child, appropriate pediatric exper-
4 tise) to provide high quality care in treating the condition.

5 **SEC. 125. PATIENT ACCESS TO OBSTETRICAL AND GYNECO-**
6 **LOGICAL CARE.**

7 (a) GENERAL RIGHTS.—

8 (1) DIRECT ACCESS.—A group health plan, and
9 a health insurance issuer offering health insurance
10 coverage, described in subsection (b) may not re-
11 quire authorization or referral by the plan, issuer, or
12 any person (including a primary care provider de-
13 scribed in subsection (b)(2)) in the case of a female
14 participant, beneficiary, or enrollee who seeks cov-
15 erage for obstetrical or gynecological care provided
16 by a participating health care professional who spe-
17 cializes in obstetrics or gynecology.

18 (2) OBSTETRICAL AND GYNECOLOGICAL
19 CARE.—A group health plan and a health insurance
20 issuer described in subsection (b) shall treat the pro-
21 vision of obstetrical and gynecological care, and the
22 ordering of related obstetrical and gynecological
23 items and services, pursuant to the direct access de-
24 scribed under paragraph (1), by a participating
25 health care professional who specializes in obstetrics

or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

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

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

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

SEC. 126. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee

1 under a group health plan, or health insurance coverage
2 offered by a health insurance issuer, if the plan or issuer
3 requires or provides for the designation of a participating
4 primary care provider for the child, the plan or issuer shall
5 permit such person to designate a physician (allopathic or
6 osteopathic) who specializes in pediatrics as the child's pri-
7 mary care provider if such provider participates in the net-
8 work of the plan or issuer.

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

13 **SEC. 127. CONTINUITY OF CARE.**

14 (a) TERMINATION OF PROVIDER.—

15 (1) IN GENERAL.—If—

16 (A) a contract between a group health
17 plan, or a health insurance issuer offering
18 health insurance coverage, and a treating health
19 care provider is terminated (as defined in para-
20 graph (e)(4)), or

21 (B) benefits or coverage provided by a
22 health care provider are terminated because of
23 a change in the terms of provider participation
24 in such plan or coverage,

1 the plan or issuer shall meet the requirements of
2 paragraph (3) with respect to each continuing care
3 patient.

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) REQUIREMENTS.—The requirements of this
19 paragraph are that the plan or issuer—

20 (A) notify the continuing care patient in-
21 volved, or arrange to have the patient notified
22 pursuant to subsection (d)(2), on a timely basis
23 of the termination described in paragraph (1)
24 (or paragraph (2), if applicable) and the right

1 to elect continued transitional care from the
2 provider under this section;
3 (B) provide the patient with an oppor-
4 tunity to notify the plan or issuer of the pa-
5 tient's need for transitional care; and
6 (C) subject to subsection (c), permit the
7 patient to elect to continue to be covered with
8 respect to the course of treatment by such pro-
9 vider with the provider's consent during a tran-
10 sitional period (as provided for under subsection
11 (b)).
12 (4) CONTINUING CARE PATIENT.—For purposes
13 of this section, the term ''continuing care patient''
14 means a participant, beneficiary, or enrollee who—
15 (A) is undergoing a course of treatment
16 for a serious and complex condition from the
17 provider at the time the plan or issuer receives
18 or provides notice of provider, benefit, or cov-
19 erage termination described in paragraph (1)
20 (or paragraph (2), if applicable);
21 (B) is undergoing a course of institutional
22 or inpatient care from the provider at the time
23 of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to a provider that was treating the terminal illness before the date of such notice.

(b) TRANSITIONAL PERIODS.—

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

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

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

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

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the surgery involved and post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(E) shall extend for the remainder of the patient's life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

1 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
2 group health plan or health insurance issuer may condi-
3 tion coverage of continued treatment by a provider under
4 this section upon the provider agreeing to the following
5 terms and conditions:

6 (1) The treating health care provider agrees to
7 accept reimbursement from the plan or issuer and
8 continuing care patient involved (with respect to
9 cost-sharing) at the rates applicable prior to the
10 start of the transitional period as payment in full
11 (or, in the case described in subsection (a)(2), at the
12 rates applicable under the replacement plan or cov-
13 erage after the date of the termination of the con-
14 tract with the group health plan or health insurance
15 issuer) and not to impose cost-sharing with respect
16 to the patient in an amount that would exceed the
17 cost-sharing that could have been imposed if the
18 contract referred to in subsection (a)(1) had not
19 been terminated.

20 (2) The treating health care provider agrees to
21 adhere to the quality assurance standards of the
22 plan or issuer responsible for payment under para-
23 graph (1) and to provide to such plan or issuer nec-
24 essary medical information related to the care pro-
25 vided.

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

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan

or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

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

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

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

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

(A) in the case of an acute illness, a condition that is serious enough to require special-

ized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section 124(b)(2)(B)).

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

SEC. 128. ACCESS TO NEEDED PRESCRIPTION DRUGS.

(a) IN GENERAL.—To the extent that a group health plan, or health insurance coverage offered by a health insurance issuer, provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan or issuer shall—

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

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

(3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medi-

1 cally necessary and appropriate and, in the case of
2 such an exception, apply the same cost-sharing re-
3 quirements that would have applied in the case of a
4 drug covered under the formulary.
5 (b) COVERAGE OF APPROVED DRUGS AND MEDICAL
6 DEVICES.—
7 (1) IN GENERAL.—A group health plan (and
8 health insurance coverage offered in connection with
9 such a plan) that provides any coverage of prescrip-
10 tion drugs or medical devices shall not deny coverage
11 of such a drug or device on the basis that the use
12 is investigational, if the use—
13 (A) in the case of a prescription drug—
14 (i) is included in the labeling author-
15 ized by the application in effect for the
16 drug pursuant to subsection (b) or (j) of
17 section 505 of the Federal Food, Drug,
18 and Cosmetic Act, without regard to any
19 postmarketing requirements that may
20 apply under such Act; or
21 (ii) is included in the labeling author-
22 ized by the application in effect for the
23 drug under section 351 of the Public
24 Health Service Act, without regard to any

1 postmarketing requirements that may
2 apply pursuant to such section; or
3 (B) in the case of a medical device, is in-
4 cluded in the labeling authorized by a regula-
5 tion under subsection (d) or (3) of section 513
6 of the Federal Food, Drug, and Cosmetic Act,
7 an order under subsection (f) of such section, or
8 an application approved under section 515 of
9 such Act, without regard to any postmarketing
10 requirements that may apply under such Act.
11 (2) CONSTRUCTION.—Nothing in this sub-
12 section shall be construed as requiring a group
13 health plan (or health insurance coverage offered in
14 connection with such a plan) to provide any coverage
15 of prescription drugs or medical devices.

16 **SEC. 129. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**
17 **APPROVED CLINICAL TRIALS.**

18 (a) COVERAGE.—
19 (1) IN GENERAL.—If a group health plan, or
20 health insurance issuer that is providing health in-
21 surance coverage, provides coverage to a qualified in-
22 dividual (as defined in subsection (b)), the plan or
23 issuer—

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

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

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

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

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

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

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

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

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

16 (2) Either—

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

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

1 such trial would be appropriate based upon the
2 individual meeting the conditions described in
3 paragraph (1).
4 (c) PAYMENT.—
5 (1) IN GENERAL.—Under this section a group
6 health plan and a health insurance issuer shall pro-
7 vide for payment for routine patient costs described
8 in subsection (a)(2) but is not required to pay for
9 costs of items and services that are reasonably ex-
10 pected (as determined by the appropriate Secretary)
11 to be paid for by the sponsors of an approved clin-
12 ical trial.
13 (2) PAYMENT RATE.—In the case of covered
14 items and services provided by—
15 (A) a participating provider, the payment
16 rate shall be at the agreed upon rate; or
17 (B) a nonparticipating provider, the pay-
18 ment rate shall be at the rate the plan or issuer
19 would normally pay for comparable services
20 under subparagraph (A).
21 (d) APPROVED CLINICAL TRIAL DEFINED.—
22 (1) IN GENERAL.—In this section, the term
23 ''approved clinical trial'' means a clinical research
24 study or clinical investigation—

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

(i) the National Institutes of Health;

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

(iii) either of the following if the conditions described in paragraph (2) are met—

(I) the Department of Veterans Affairs;

(II) the Department of Defense; or

(B) approved by the Food and Drug Administration.

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

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

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

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

SEC. 130. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) INPATIENT CARE.—

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

(A) a mastectomy;

(B) a lumpectomy; or

1 (C) a lymph node dissection for the treat-
2 ment of breast cancer.
3 (2) EXCEPTION.—Nothing in this section shall
4 be construed as requiring the provision of inpatient
5 coverage if the attending physician and patient de-
6 termine that a shorter period of hospital stay is
7 medically appropriate.
8 (b) PROHIBITION ON CERTAIN MODIFICATIONS.—In
9 implementing the requirements of this section, a group
10 health plan, and a health insurance issuer providing health
11 insurance coverage, may not modify the terms and condi-
12 tions of coverage based on the determination by a partici-
13 pant, beneficiary, or enrollee to request less than the min-
14 imum coverage required under subsection (a).
15 (c) SECONDARY CONSULTATIONS.—
16 (1) IN GENERAL.—A group health plan, and a
17 health insurance issuer providing health insurance
18 coverage, that provides coverage with respect to
19 medical and surgical services provided in relation to
20 the diagnosis and treatment of cancer shall ensure
21 that full coverage is provided for secondary consulta-
22 tions by specialists in the appropriate medical fields
23 (including pathology, radiology, and oncology) to
24 confirm or refute such diagnosis. Such plan or issuer
25 shall ensure that full coverage is provided for such

1 secondary consultation whether such consultation is
2 based on a positive or negative initial diagnosis. In
3 any case in which the attending physician certifies in
4 writing that services necessary for such a secondary
5 consultation are not sufficiently available from spe-
6 cialists operating under the plan or coverage with re-
7 spect to whose services coverage is otherwise pro-
8 vided under such plan or by such issuer, such plan
9 or issuer shall ensure that coverage is provided with
10 respect to the services necessary for the secondary
11 consultation with any other specialist selected by the
12 attending physician for such purpose at no addi-
13 tional cost to the individual beyond that which the
14 individual would have paid if the specialist was par-
15 ticipating in the network of the plan or issuer.
16 (2) EXCEPTION.—Nothing in paragraph (1)
17 shall be construed as requiring the provision of sec-
18 ondary consultations where the patient determines
19 not to seek such a consultation.
20 (d) PROHIBITION ON PENALTIES OR INCENTIVES.—
21 A group health plan, and a health insurance issuer pro-
22 viding health insurance coverage, may not—
23 (1) penalize or otherwise reduce or limit the re-
24 imbursement of a provider or specialist because the
25 provider or specialist provided care to a participant,

1 beneficiary, or enrollee in accordance with this sec-
2 tion;
3 (2) provide financial or other incentives to a
4 physician or specialist to induce the physician or
5 specialist to keep the length of inpatient stays of pa-
6 tients following a mastectomy, lumpectomy, or a
7 lymph node dissection for the treatment of breast
8 cancer below certain limits or to limit referrals for
9 secondary consultations; or
10 (3) provide financial or other incentives to a
11 physician or specialist to induce the physician or
12 specialist to refrain from referring a participant,
13 beneficiary, or enrollee for a secondary consultation
14 that would otherwise be covered by the plan or cov-
15 erage involved under subsection (c).

16 **CHAPTER 3—ACCESS TO INFORMATION**

17 **SEC. 131. PATIENT ACCESS TO INFORMATION.**

18 (a) REQUIREMENT.—
19 (1) DISCLOSURE.—
20 (A) IN GENERAL.—A group health plan,
21 and a health insurance issuer that provides cov-
22 erage in connection with health insurance cov-
23 erage, shall provide for the disclosure to partici-
24 pants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

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

(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year; and

(iii) of information relating to any material reduction to the benefits or information described in such subsection or subsection (c), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect.

(B) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under subparagraph (A) shall be provided—

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

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each option available under the group health plan or health insurance coverage the following:

(1) BENEFITS.—A description of the covered benefits, including—

(A) any in- and out-of-network benefits;

(B) specific preventive services covered under the plan or coverage if such services are covered;

(C) any specific exclusions or express limitations of benefits described in section 114(d)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

(E) any definition of medical necessity used in making coverage determinations by the plan, issuer, or claims administrator.

(2) COST SHARING.—A description of any cost-sharing requirements, including—

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

(C) any cost-sharing requirements for out-of-network benefits or services received from nonparticipating providers; and

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

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

(4) SERVICE AREA.—A description of the plan or issuer's service area, including the provision of any out-of-area coverage.

(5) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients.

(6) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants, beneficiaries, and enrollees

in selecting, accessing, or changing their primary care provider, including providers both within and outside of the network (if the plan or issuer permits out-of-network services), and the right to select a pediatrician as a primary care provider under section 126 for a participant, beneficiary, or enrollee who is a child if such section applies.

(7) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

(8) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(9) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 122(b)(2) and the right to timely

1 access to specialists care under section 124 if such
2 section applies.
3 (10) CLINICAL TRIALS.—A description of the
4 circumstances and conditions under which participa-
5 tion in clinical trials is covered under the terms and
6 conditions of the plan or coverage, and the right to
7 obtain coverage for approved clinical trials under
8 section 129 if such section applies.
9 (11) PRESCRIPTION DRUGS.—To the extent the
10 plan or issuer provides coverage for prescription
11 drugs, a statement of whether such coverage is lim-
12 ited to drugs included in a formulary, a description
13 of any provisions and cost-sharing required for ob-
14 taining on- and off-formulary medications, and a de-
15 scription of the rights of participants, beneficiaries,
16 and enrollees in obtaining access to access to pre-
17 scription drugs under section 128 if such section ap-
18 plies.
19 (12) EMERGENCY SERVICES.—A summary of
20 the rules and procedures for accessing emergency
21 services, including the right of a participant, bene-
22 ficiary, or enrollee to obtain emergency services
23 under the prudent layperson standard under section
24 123, if such section applies, and any educational in-

1 formation that the plan or issuer may provide re-
2 garding the appropriate use of emergency services.
3 (13) CLAIMS AND APPEALS.—A description of
4 the plan or issuer's rules and procedures pertaining
5 to claims and appeals, a description of the rights
6 (including deadlines for exercising rights) of partici-
7 pants, beneficiaries, and enrollees under chapter 1 in
8 obtaining covered benefits, filing a claim for bene-
9 fits, and appealing coverage decisions internally and
10 externally (including telephone numbers and mailing
11 addresses of the appropriate authority), and a de-
12 scription of any additional legal rights and remedies
13 available under section 502 of the Employee Retire-
14 ment Income Security Act of 1974 and applicable
15 State law.
16 (14) ADVANCE DIRECTIVES AND ORGAN DONA-
17 TION.—A description of procedures for advance di-
18 rectives and organ donation decisions if the plan or
19 issuer maintains such procedures.
20 (15) INFORMATION ON PLANS AND ISSUERS.—
21 The name, mailing address, and telephone number
22 or numbers of the plan administrator and the issuer
23 to be used by participants, beneficiaries, and enroll-
24 ees seeking information about plan or coverage bene-
25 fits and services, payment of a claim, or authoriza-

1 tion for services and treatment. Notice of whether
2 the benefits under the plan or coverage are provided
3 under a contract or policy of insurance issued by an
4 issuer, or whether benefits are provided directly by
5 the plan sponsor who bears the insurance risk.

6 (16) TRANSLATION SERVICES.—A summary de-
7 scription of any translation or interpretation services
8 (including the availability of printed information in
9 languages other than English, audio tapes, or infor-
10 mation in Braille) that are available for non-English
11 speakers and participants, beneficiaries, and enroll-
12 ees with communication disabilities and a description
13 of how to access these items or services.

14 (17) ACCREDITATION INFORMATION.—Any in-
15 formation that is made public by accrediting organi-
16 zations in the process of accreditation if the plan or
17 issuer is accredited, or any additional quality indica-
18 tors (such as the results of enrollee satisfaction sur-
19 veys) that the plan or issuer makes public or makes
20 available to participants, beneficiaries, and enrollees.

21 (18) NOTICE OF REQUIREMENTS.—A descrip-
22 tion of any rights of participants, beneficiaries, and
23 enrollees that are established by the Bipartisan Pa-
24 tient Protection Act (excluding those described in
25 paragraphs (1) through (17)) if such sections apply.

The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

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

(20) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each such decisionmaker.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee shall include for each option avail-

able under a group health plan or health insurance coverage the following:

(1) STATUS OF PROVIDERS.—The State licensure status of the plan or issuer's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

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

(3) PRESCRIPTION DRUGS.—Information about whether a specific prescription medication is included in the formulary of the plan or issuer, if the plan or issuer uses a defined formulary.

(4) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under

1 sections 111 and 112, including any drug formulary
2 program under section 128.
3 (5) EXTERNAL APPEALS INFORMATION.—Ag-
4 gregate information on the number and outcomes of
5 external medical reviews, relative to the sample size
6 (such as the number of covered lives) under the plan
7 or under the coverage of the issuer.
8 (d) MANNER OF DISCLOSURE.—The information de-
9 scribed in this section shall be disclosed in an accessible
10 medium and format that is calculated to be understood
11 by a participant or enrollee.
12 (e) RULES OF CONSTRUCTION.—Nothing in this sec-
13 tion shall be construed to prohibit a group health plan,
14 or a health insurance issuer in connection with health in-
15 surance coverage, from—
16 (1) distributing any other additional informa-
17 tion determined by the plan or issuer to be impor-
18 tant or necessary in assisting participants, bene-
19 ficiaries, and enrollees in the selection of a health
20 plan or health insurance coverage; and
21 (2) complying with the provisions of this section
22 by providing information in brochures, through the
23 Internet or other electronic media, or through other
24 similar means, so long as—

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

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

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed

and provides the information in printed form if the information is not received.

CHAPTER 4—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

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

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

SEC. 142. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

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

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

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

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

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

SEC. 143. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1852(j)(4) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1852(j)(4) of the Social Security Act to the Secretary, a Medicare+Choice organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

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

SEC. 144. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or

issuer, in a manner that is no less protective than the provisions of section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2)).

SEC. 145. PROTECTION FOR PATIENT ADVOCACY.

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

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

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

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

1 tation body, or appropriate management per-
2 sonnel of the plan or issuer; or
3 (B) initiates, cooperates, or otherwise par-
4 ticipates in an investigation or proceeding by
5 such an agency with respect to such care, serv-
6 ices, or conditions.
7 If an institutional health care provider is a partici-
8 pating provider with such a plan or issuer or other-
9 wise receives payments for benefits provided by such
10 a plan or issuer, the provisions of the previous sen-
11 tence shall apply to the provider in relation to care,
12 services, or conditions affecting one or more patients
13 within an institutional health care provider in the
14 same manner as they apply to the plan or issuer in
15 relation to care, services, or conditions provided to
16 one or more participants, beneficiaries, or enrollees;
17 and for purposes of applying this sentence, any ref-
18 erence to a plan or issuer is deemed a reference to
19 the institutional health care provider.
20 (2) GOOD FAITH ACTION.—For purposes of
21 paragraph (1), a protected health care professional
22 is considered to be acting in good faith with respect
23 to disclosure of information or participation if, with
24 respect to the information disclosed as part of the
25 action—

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

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

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

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

(3) EXCEPTION AND SPECIAL RULE.—

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

of confidentiality of communications provided by such law.

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

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

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

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

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory

1 agency and the information disclosed is
2 limited to the scope of the investigation or
3 proceeding.

4 (4) ADDITIONAL CONSIDERATIONS.—It shall
5 not be a violation of paragraph (1) to take an ad-
6 verse action against a protected health care profes-
7 sional if the plan, issuer, or provider taking the ad-
8 verse action involved demonstrates that it would
9 have taken the same adverse action even in the ab-
10 sence of the activities protected under such para-
11 graph.

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

19 (6) CONSTRUCTIONS.—

20 (A) DETERMINATIONS OF COVERAGE.—
21 Nothing in this subsection shall be construed to
22 prohibit a plan or issuer from making a deter-
23 mination not to pay for a particular medical
24 treatment or service or the services of a type of
25 health care professional.

1 (B) ENFORCEMENT OF PEER REVIEW PRO-
2 TOCOLS AND INTERNAL PROCEDURES.—Noth-
3 ing in this subsection shall be construed to pro-
4 hibit a plan, issuer, or provider from estab-
5 lishing and enforcing reasonable peer review or
6 utilization review protocols or determining
7 whether a protected health care professional has
8 complied with those protocols or from estab-
9 lishing and enforcing internal procedures for
10 the purpose of addressing quality concerns.
11 (C) RELATION TO OTHER RIGHTS.—Noth-
12 ing in this subsection shall be construed to
13 abridge rights of participants, beneficiaries, en-
14 rollees, and protected health care professionals
15 under other applicable Federal or State laws.
16 (7) PROTECTED HEALTH CARE PROFESSIONAL
17 DEFINED.—For purposes of this subsection, the
18 term ''protected health care professional'' means an
19 individual who is a licensed or certified health care
20 professional and who—
21 (A) with respect to a group health plan or
22 health insurance issuer, is an employee of the
23 plan or issuer or has a contract with the plan
24 or issuer for provision of services for which ben-
25 efits are available under the plan or issuer; or

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

CHAPTER 5—DEFINITIONS

SEC. 151. DEFINITIONS.

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

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this subtitle under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this subtitle under section 714 of the Employee Retirement Income Security Act of 1974.

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

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

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

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

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

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

1 (4) HEALTH CARE PROFESSIONAL.—The term
2 ''health care professional'' means an individual who
3 is licensed, accredited, or certified under State law
4 to provide specified health care services and who is
5 operating within the scope of such licensure, accredi-
6 tation, or certification.
7 (5) HEALTH CARE PROVIDER.—The term
8 ''health care provider'' includes a physician or other
9 health care professional, as well as an institutional
10 or other facility or agency that provides health care
11 services and that is licensed, accredited, or certified
12 to provide health care items and services under ap-
13 plicable State law.
14 (6) NETWORK.—The term ''network'' means,
15 with respect to a group health plan or health insur-
16 ance issuer offering health insurance coverage, the
17 participating health care professionals and providers
18 through whom the plan or issuer provides health
19 care items and services to participants, beneficiaries,
20 or enrollees.
21 (7) NONPARTICIPATING.—The term ''non-
22 participating'' means, with respect to a health care
23 provider that provides health care items and services
24 to a participant, beneficiary, or enrollee under group
25 health plan or health insurance coverage, a health

1 care provider that is not a participating health care
2 provider with respect to such items and services.
3 (8) PARTICIPATING.—The term ''participating''
4 means, with respect to a health care provider that
5 provides health care items and services to a partici-
6 pant, beneficiary, or enrollee under group health
7 plan or health insurance coverage offered by a
8 health insurance issuer, a health care provider that
9 furnishes such items and services under a contract
10 or other arrangement with the plan or issuer.
11 (9) PRIOR AUTHORIZATION.—The term ''prior
12 authorization'' means the process of obtaining prior
13 approval from a health insurance issuer or group
14 health plan for the provision or coverage of medical
15 services.
16 (10) TERMS AND CONDITIONS.—The term
17 ''terms and conditions'' includes, with respect to a
18 group health plan or health insurance coverage, re-
19 quirements imposed under this subtitle with respect
20 to the plan or coverage.

21 **SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**
22 **TION.**

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

1 (1) IN GENERAL.—Subject to paragraph (2),
2 this subtitle shall not be construed to supersede any
3 provision of State law which establishes, implements,
4 or continues in effect any standard or requirement
5 solely relating to health insurance issuers (in connec-
6 tion with group health insurance coverage or other-
7 wise) except to the extent that such standard or re-
8 quirement prevents the application of a requirement
9 of this subtitle.
10 (2) CONTINUED PREEMPTION WITH RESPECT
11 TO GROUP HEALTH PLANS.—Nothing in this subtitle
12 shall be construed to affect or modify the provisions
13 of section 514 of the Employee Retirement Income
14 Security Act of 1974 with respect to group health
15 plans.
16 (3) CONSTRUCTION.—In applying this section,
17 a State law that provides for equal access to, and
18 availability of, all categories of licensed health care
19 providers and services shall not be treated as pre-
20 venting the application of any requirement of this
21 subtitle.
22 (b) APPLICATION OF SUBSTANTIALLY COMPLIANT
23 STATE LAWS.—
24 (1) IN GENERAL.—In the case of a State law
25 that imposes, with respect to health insurance cov-

erage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this title (except in the case of other substantially compliant requirements), in applying the requirements of this subtitle under section 2707 and 2753 (as applicable) of the Public Health Service Act (as added by subtitle B), subject to subsection (a)(2)—

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

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

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

(3) DEFINITIONS.—In this section:

1 (A) PATIENT PROTECTION REQUIRE-
2 MENT.—The term ''patient protection require-
3 ment'' means a requirement under this subtitle,
4 and includes (as a single requirement) a group
5 or related set of requirements under a section
6 or similar unit under this subtitle.
7 (B) SUBSTANTIALLY COMPLIANT.—The
8 terms ''substantially compliant'', substantially
9 complies'', or ''substantial compliance'' with re-
10 spect to a State law, mean that the State law
11 has the same or similar features as the patient
12 protection requirements and has a similar ef-
13 fect.
14 (c) DETERMINATIONS OF SUBSTANTIAL COMPLI-
15 ANCE.—
16 (1) CERTIFICATION BY STATES.—A State may
17 submit to the Secretary a certification that a State
18 law provides for patient protections that are at least
19 substantially compliant with one or more patient
20 protection requirements. Such certification shall be
21 accompanied by such information as may be re-
22 quired to permit the Secretary to make the deter-
23 mination described in paragraph (2)(A).
24 (2) REVIEW.—

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

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified ad-

1 ditional information is received by the Sec-
2 retary.
3 (3) APPROVAL.—
4 (A) IN GENERAL.—The Secretary shall ap-
5 prove a certification under paragraph (1) un-
6 less—
7 (i) the State fails to provide sufficient
8 information to enable the Secretary to
9 make a determination under paragraph
10 (2)(A); or
11 (ii) the Secretary determines that the
12 State law involved does not provide for pa-
13 tient protections that substantially comply
14 with the patient protection requirement (or
15 requirements) to which the law relates.
16 (B) STATE CHALLENGE.—A State that has
17 a certification disapproved by the Secretary
18 under subparagraph (A) may challenge such
19 disapproval in the appropriate United States
20 district court.
21 (C) DEFERENCE TO STATES.—With re-
22 spect to a certification submitted under para-
23 graph (1), the Secretary shall give deference to
24 the State's interpretation of the State law in-

1 volved with respect to the patient protection in-
2 volved.
3 (D) PUBLIC NOTIFICATION.—The Sec-
4 retary shall—
5 (i) provide a State with a notice of the
6 determination to approve or disapprove a
7 certification under this paragraph;
8 (ii) promptly publish in the Federal
9 Register a notice that a State has sub-
10 mitted a certification under paragraph (1);
11 (iii) promptly publish in the Federal
12 Register the notice described in clause (i)
13 with respect to the State; and
14 (iv) annually publish the status of all
15 States with respect to certifications.
16 (4) CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as preventing the certifi-
18 cation (and approval of certification) of a State law
19 under this subsection solely because it provides for
20 greater protections for patients than those protec-
21 tions otherwise required to establish substantial
22 compliance.
23 (5) PETITIONS.—
24 (A) PETITION PROCESS.—Effective on the
25 date on which the provisions of this title become

effective, as provided for in section 181, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this subtitle.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

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

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

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the

1 Virgin Islands, Guam, American Samoa, the North-
2 ern Mariana Islands, any political subdivisions of
3 such, or any agency or instrumentality of such.

4 **SEC. 153. EXCLUSIONS.**

5 (a) NO BENEFIT REQUIREMENTS.—Nothing in this
6 subtitle shall be construed to require a group health plan
7 or a health insurance issuer offering health insurance cov-
8 erage to include specific items and services under the
9 terms of such a plan or coverage, other than those pro-
10 vided under the terms and conditions of such plan or cov-
11 erage.

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

14 (1) IN GENERAL.—The provisions of sections
15 121 through 127 shall not apply to a group health
16 plan or health insurance coverage if the only cov-
17 erage offered under the plan or coverage is fee-for-
18 service coverage (as defined in paragraph (2)).

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

23 (A) reimburses hospitals, health profes-
24 sionals, and other providers on a fee-for-service

basis without placing the provider at financial risk;

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

(C) allows access to any provider that is lawfully authorized to provide the covered services and that agrees to accept the terms and conditions of payment established under the plan or by the issuer; and

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

SEC. 154. TREATMENT OF EXCEPTED BENEFITS.

(a) IN GENERAL.—The requirements of this subtitle and the provisions of sections 502(a)(1)(C), 502(n), and 514(d) of the Employee Retirement Income Security Act of 1974 (added by section 172) shall not apply to excepted benefits (as defined in section 733(c) of such Act), other than benefits described in section 733(c)(2)(A) of such Act, in the same manner as the provisions of part 7 of subtitle B of title I of such Act do not apply to such benefits under subsections (b) and (c) of section 732 of such Act.

(b) COVERAGE OF CERTAIN LIMITED SCOPE PLANS.—Only for purposes of applying the requirements of this subtitle under sections 2707 and 2753 of the Public Health Service Act, section 714 of the Employee Retirement Income Security Act of 1974, and section 9813 of the Internal Revenue Code of 1986, the following sections shall be deemed not to apply:

(1) Section 2791(c)(2)(A) of the Public Health Service Act.

(2) Section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974.

(3) Section 9832(c)(2)(A) of the Internal Revenue Code of 1986.

SEC. 155. REGULATIONS.

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

SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

The requirements of this subtitle with respect to a group health plan or health insurance coverage are, subject to section 154, deemed to be incorporated into, and made a part of, such plan or the policy, certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

SEC. 157. PRESERVATION OF PROTECTIONS.

(a) IN GENERAL.—The rights under this title (including the right to maintain a civil action and any other rights under the amendments made by this title) may not be waived, deferred, or lost pursuant to any agreement not authorized under this title.

(b) EXCEPTION.—Subsection (a) shall not apply to an agreement providing for arbitration or participation in any other nonjudicial procedure to resolve a dispute if the agreement is entered into knowingly and voluntarily by the parties involved after the dispute has arisen or is pursuant to the terms of a collective bargaining agreement. Nothing in this subsection shall be construed to permit the waiver of the requirements of sections 113 and 114 (relating to internal and external review).

Subtitle B—Application of Quality Care Standards to Group Health Plans and Health Insurance Coverage Under the Public Health Service Act

SEC. 161. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

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

"SEC. 2707. PATIENT PROTECTION STANDARDS.

''Each group health plan shall comply with patient protection requirements under subtitle A of the Bipartisan Patient Protection Act, and each health insurance issuer shall comply with patient protection requirements under such subtitle with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

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

SEC. 162. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

"SEC. 2753. PATIENT PROTECTION STANDARDS.

''Each health insurance issuer shall comply with patient protection requirements under subtitle A of the Bipartisan Patient Protection Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

SEC. 163. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

"SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

Subtitle C—Amendments to the Employee Retirement Income Security Act of 1974

SEC. 171. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

"SEC. 714. PATIENT PROTECTION STANDARDS.

"(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of subtitle A of the Bipartisan Patient Protection Act (as in effect as of the date of the enactment of such Act), and such re-

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

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

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

17 "(A) Section 121 (relating to consumer
18 choice option).

19 "(B) Section 122 (relating to choice of
20 health care professional).

21 "(C) Section 123 (relating to access to
22 emergency care).

23 "(D) Section 124 (relating to timely access
24 to specialists).

"(E) Section 125 (relating to patient access to obstetrical and gynecological care).

"(F) Section 126 (relating to access to pediatric care).

"(G) Section 127 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

"(H) Section 128 (relating to access to needed prescription drugs).

"(I) Section 129 (relating to coverage for individuals participating in approved clinical trials).

"(J) Section 130 (relating to required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations).

"(K) Section 144 (relating to payment of claims).

"(2) INFORMATION.—With respect to information required to be provided or made available under section 131 of the Bipartisan Patient Protection Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary

shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

"(3) INTERNAL APPEALS.—With respect to the internal appeals process required to be established under section 113 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

"(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 114 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

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 of the Bipar-
6 tisan Patient Protection Act, the group health plan
7 shall not be liable for such violation unless the plan
8 caused such violation:
9 "(A) Section 141 (relating to prohibition of
10 interference with certain medical communica-
11 tions).
12 "(B) Section 142 (relating to prohibition
13 of discrimination against providers based on li-
14 censure).
15 "(C) Section 143 (relating to prohibition
16 against improper incentive arrangements).
17 "(D) Section 145 (relating to protection
18 for patient advocacy).
19 "(6) CONSTRUCTION.—Nothing in this sub-
20 section shall be construed to affect or modify the re-
21 sponsibilities of the fiduciaries of a group health
22 plan under part 4 of subtitle B.
23 "(7) TREATMENT OF SUBSTANTIALLY COMPLI-
24 ANT STATE LAWS.—For purposes of applying this
25 subsection in connection with health insurance cov-

1 erage, any reference in this subsection to a require-
2 ment in a section or other provision in the Bipar-
3 tisan Patient Protection Act with respect to a health
4 insurance issuer is deemed to include a reference to
5 a requirement under a State law that substantially
6 complies (as determined under section 152(c) of
7 such Act) with the requirement in such section or
8 other provisions.

9 "(8) APPLICATION TO CERTAIN PROHIBITIONS
10 AGAINST RETALIATION.—With respect to compliance
11 with the requirements of section 145(b)(1) of the Bi-
12 partisan Patient Protection Act, for purposes of this
13 subtitle the term 'group health plan' is deemed to in-
14 clude a reference to an institutional health care pro-
15 vider.

16 "(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

17 "(1) COMPLAINTS.—Any protected health care
18 professional who believes that the professional has
19 been retaliated or discriminated against in violation
20 of section 145(b)(1) of the Bipartisan Patient Pro-
21 tection Act may file with the Secretary a complaint
22 within 180 days of the date of the alleged retaliation
23 or discrimination.

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

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

7 ''(d) CONFORMING REGULATIONS.—The Secretary
8 shall issue regulations to coordinate the requirements on
9 group health plans and health insurance issuers under this
10 section with the requirements imposed under the other
11 provisions of this title. In order to reduce duplication and
12 clarify the rights of participants and beneficiaries with re-
13 spect to information that is required to be provided, such
14 regulations shall coordinate the information disclosure re-
15 quirements under section 131 of the Bipartisan Patient
16 Protection Act with the reporting and disclosure require-
17 ments imposed under part 1, so long as such coordination
18 does not result in any reduction in the information that
19 would otherwise be provided to participants and bene-
20 ficiaries.''.

21 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
22 REQUIREMENT.—Section 503 of such Act (29 U.S.C.
23 1133) is amended by inserting ''(a)'' after ''SEC. 503.''
24 and by adding at the end the following new subsection:

"(b) In the case of a group health plan (as defined in section 733), compliance with the requirements of chapter 1 of subtitle A of the Bipartisan Patient Protection Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial, shall be deemed compliance with subsection (a) with respect to such claims denial.".

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

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

"Sec. 714. Patient protection standards.".

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

SEC. 172. AVAILABILITY OF CIVIL REMEDIES.

(a) AVAILABILITY OF FEDERAL CIVIL REMEDIES IN CASES NOT INVOLVING MEDICALLY REVIEWABLE DECISIONS.—

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

1 "(n) CAUSE OF ACTION RELATING TO PROVISION OF
2 HEALTH BENEFITS.—
3 "(1) IN GENERAL.—In any case in which—
4 "(A) a person who is a fiduciary of a
5 group health plan, a health insurance issuer of-
6 fering health insurance coverage in connection
7 with the plan, or an agent of the plan, issuer,
8 or plan sponsor, upon consideration of a claim
9 for benefits of a participant or beneficiary
10 under section 112 of the Bipartisan Patient
11 Protection Act (relating to procedures for initial
12 claims for benefits and prior authorization de-
13 terminations) or upon review of a denial of such
14 a claim under section 113 of such Act (relating
15 to internal appeal of a denial of a claim for ben-
16 efits), fails to exercise ordinary care in making
17 a decision—
18 "(i) regarding whether an item or
19 service is covered under the terms and con-
20 ditions of the plan or coverage,
21 "(ii) regarding whether an individual
22 is a participant or beneficiary who is en-
23 rolled under the terms and conditions of
24 the plan or coverage (including the applica-

bility of any waiting period under the plan or coverage), or

"(iii) as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage, and

"(B) such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary,

such plan, plan sponsor, or issuer shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and non-economic damages (but not exemplary or punitive damages) in connection with such personal injury or death.

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

"(A) IN GENERAL.—A cause of action is established under paragraph (1)(A) only if the decision referred to in paragraph (1)(A) does not include a medically reviewable decision.

"(B) MEDICALLY REVIEWABLE DECISION.—For purposes of this subsection, the

term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 114(d)(2) of the Bipartisan Patient Protection Act (relating to medically reviewable decisions).

"(3) LIMITATION REGARDING CERTAIN TYPES OF ACTIONS SAVED FROM PREEMPTION OF STATE LAW.—A cause of action is not established under paragraph (1)(A) in connection with a failure described in paragraph (1)(A) to the extent that a cause of action under State law (as defined in section 514(c)) for such failure would not be preempted under section 514.

"(4) DEFINITIONS AND RELATED RULES.—For purposes of this subsection and subsection (o)—

"(A) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

"(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and in-

1 cludes an injury arising out of the treatment
2 (or failure to treat) a mental illness or disease.
3 "(C) CLAIM FOR BENEFITS; DENIAL.—The
4 terms 'claim for benefits' and 'denial of a claim
5 for benefits' have the meanings provided such
6 terms in section 112(e) of the Bipartisan Pa-
7 tient Protection Act.
8 "(D) TERMS AND CONDITIONS.—The term
9 'terms and conditions' includes, with respect to
10 a group health plan or health insurance cov-
11 erage, requirements imposed under subtitle A of
12 the Bipartisan Patient Protection Act.
13 "(E) TREATMENT OF EXCEPTED BENE-
14 FITS.—Under section 154(a) of the Bipartisan
15 Patient Protection Act, the provisions of this
16 subsection and subsection (a)(1)(C) do not
17 apply to certain excepted benefits.
18 "(F) GROUP HEALTH PLAN AND OTHER
19 RELATED TERMS.—The provisions of sections
20 732(d) and 733 apply for purposes of this sub-
21 section in the same manner as they apply for
22 purposes of part 7, except that the term 'group
23 health plan' includes a group health plan (as
24 defined in section 607(1)).

1 "(5) EXCLUSION OF EMPLOYERS AND OTHER
2 PLAN SPONSORS.—
3 "(A) CAUSES OF ACTION AGAINST EM-
4 PLOYERS AND PLAN SPONSORS PRECLUDED.—
5 Subject to subparagraph (B), paragraph (1)(A)
6 does not authorize a cause of action against an
7 employer or other plan sponsor maintaining the
8 plan (or against an employee of such an em-
9 ployer or sponsor acting within the scope of em-
10 ployment).
11 "(B) CERTAIN CAUSES OF ACTION PER-
12 MITTED.—Notwithstanding subparagraph (A),
13 a cause of action may arise against an employer
14 or other plan sponsor (or against an employee
15 of such an employer or sponsor acting within
16 the scope of employment) under paragraph
17 (1)(A), to the extent there was direct participa-
18 tion by the employer or other plan sponsor (or
19 employee) in the decision of the plan under sec-
20 tion 112 of the Bipartisan Patient Protection
21 Act upon consideration of a claim for benefits
22 or under section 113 of such Act upon review
23 of a denial of a claim for benefits.
24 "(C) DIRECT PARTICIPATION.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in paragraph (1)(A), the actual making of such decision or the actual exercise of control in making such decision.

"(ii) RULES OF CONSTRUCTION.—For purposes of clause (i), the employer or plan sponsor (or employee) shall not be construed to be engaged in direct participation because of any form of decisionmaking or other conduct that is merely collateral or precedent to the decision described in paragraph (1)(A) on a particular claim for benefits of a participant or beneficiary, including (but not limited to)—

"(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

"(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis

1 undertaken in connection with the se-
2 lection of, or continued maintenance
3 of, the plan or coverage involved;
4 "(III) any participation by the
5 employer or other plan sponsor (or
6 employee) in the process of creating,
7 continuing, modifying, or terminating
8 the plan or any benefit under the
9 plan, if such process was not substan-
10 tially focused solely on the particular
11 situation of the participant or bene-
12 ficiary referred to in paragraph
13 (1)(A); and
14 "(IV) any participation by the
15 employer or other plan sponsor (or
16 employee) in the design of any benefit
17 under the plan, including the amount
18 of copayment and limits connected
19 with such benefit.
20 "(iii) IRRELEVANCE OF CERTAIN COL-
21 LATERAL EFFORTS MADE BY EMPLOYER
22 OR PLAN SPONSOR.—For purposes of this
23 subparagraph, an employer or plan sponsor
24 shall not be treated as engaged in direct
25 participation in a decision with respect to

1 any claim for benefits or denial thereof in
2 the case of any particular participant or
3 beneficiary solely by reason of—
4 "(I) any efforts that may have
5 been made by the employer or plan
6 sponsor to advocate for authorization
7 of coverage for that or any other par-
8 ticipant or beneficiary (or any group
9 of participants or beneficiaries), or
10 "(II) any provision that may
11 have been made by the employer or
12 plan sponsor for benefits which are
13 not covered under the terms and con-
14 ditions of the plan for that or any
15 other participant or beneficiary (or
16 any group of participants or bene-
17 ficiaries).
18 "(D) APPLICATION TO CERTAIN PLANS.—
19 "(i) IN GENERAL.—Notwithstanding
20 any other provision of this subsection, no
21 group health plan described in clause (ii)
22 (or plan sponsor of such a plan) shall be
23 liable under paragraph (1) for the perform-
24 ance of, or the failure to perform, any non-
25 medically reviewable duty under the plan.

1 "(ii) DEFINITION.—A group health
2 plan described in this clause is—
3 "(I) a group health plan that is
4 self-insured and self administered by
5 an employer (including an employee of
6 such an employer acting within the
7 scope of employment); or
8 "(II) a multiemployer plan as de-
9 fined in section 3(37)(A) (including
10 an employee of a contributing em-
11 ployer or of the plan, or a fiduciary
12 of the plan, acting within the scope of
13 employment or fiduciary responsi-
14 bility) that is self-insured and self-ad-
15 ministered.
16 "(6) EXCLUSION OF PHYSICIANS AND OTHER
17 HEALTH CARE PROFESSIONALS.—
18 "(A) IN GENERAL.—No treating physician
19 or other treating health care professional of the
20 participant or beneficiary, and no person acting
21 under the direction of such a physician or
22 health care professional, shall be liable under
23 paragraph (1) for the performance of, or the
24 failure to perform, any non-medically reviewable
25 duty of the plan, the plan sponsor, or any

1 health insurance issuer offering health insur-
2 ance coverage in connection with the plan.
3 "(B) DEFINITIONS.—For purposes of sub-
4 paragraph (A)—
5 "(i) HEALTH CARE PROFESSIONAL.—
6 The term 'health care professional' means
7 an individual who is licensed, accredited, or
8 certified under State law to provide speci-
9 fied health care services and who is oper-
10 ating within the scope of such licensure,
11 accreditation, or certification.
12 "(ii) NON-MEDICALLY REVIEWABLE
13 DUTY.—The term 'non-medically review-
14 able duty' means a duty the discharge of
15 which does not include the making of a
16 medically reviewable decision.
17 "(7) EXCLUSION OF HOSPITALS.—No treating
18 hospital of the participant or beneficiary shall be lia-
19 ble under paragraph (1) for the performance of, or
20 the failure to perform, any non-medically reviewable
21 duty (as defined in paragraph (6)(B)(ii)) of the
22 plan, the plan sponsor, or any health insurance
23 issuer offering health insurance coverage in connec-
24 tion with the plan.

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

"(9) REQUIREMENT OF EXHAUSTION.—

"(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 112 and 113 of the Bipartisan Patient Protection Act (if applicable) have been exhausted.

"(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 112, 113, or 114 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm

to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

"(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

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

"(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or

1 such action in determining the amount of the
2 damages awarded.
3 "(D) ADMISSIBLE.—Any determination
4 made by a reviewer in an administrative pro-
5 ceeding under section 113 of the Bipartisan Pa-
6 tient Protection Act shall be admissible in any
7 Federal court proceeding and shall be presented
8 to the trier of fact.
9 "(10) STATUTORY DAMAGES.—
10 "(A) IN GENERAL.—The remedies set
11 forth in this subsection (n) shall be the exclu-
12 sive remedies for causes of action brought
13 under this subsection.
14 "(B) ASSESSMENT OF CIVIL PENALTIES.—
15 In addition to the remedies provided for in
16 paragraph (1) (relating to the failure to provide
17 contract benefits in accordance with the plan),
18 a civil assessment, in an amount not to exceed
19 $5,000,000, payable to the claimant may be
20 awarded in any action under such paragraph if
21 the claimant establishes by clear and convincing
22 evidence that the alleged conduct carried out by
23 the defendant demonstrated bad faith and fla-
24 grant disregard for the rights of the participant
25 or beneficiary under the plan and was a proxi-

1 mate cause of the personal injury or death that
2 is the subject of the claim.
3 "(11) LIMITATION ON ATTORNEYS' FEES.—
4 "(A) IN GENERAL.—Notwithstanding any
5 other provision of law, or any arrangement,
6 agreement, or contract regarding an attorney's
7 fee, the amount of an attorney's contingency fee
8 allowable for a cause of action brought pursu-
9 ant to this subsection shall not exceed ⅓ of the
10 total amount of the plaintiff's recovery (not in-
11 cluding the reimbursement of actual out-of-
12 pocket expenses of the attorney).
13 "(B) DETERMINATION BY DISTRICT
14 COURT.—The last Federal district court in
15 which the action was pending upon the final
16 disposition, including all appeals, of the action
17 shall have jurisdiction to review the attorney's
18 fee to ensure that the fee is a reasonable one.
19 "(12) LIMITATION OF ACTION.—Paragraph (1)
20 shall not apply in connection with any action com-
21 menced after 3 years after the later of—
22 "(A) the date on which the plaintiff first
23 knew, or reasonably should have known, of the
24 personal injury or death resulting from the fail-
25 ure described in paragraph (1), or

"(B) the date as of which the requirements of paragraph (9) are first met.

"(13) TOLLING PROVISION.—The statute of limitations for any cause of action arising under State law relating to a denial of a claim for benefits that is the subject of an action brought in Federal court under this subsection shall be tolled until such time as the Federal court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the Federal court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

"(14) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

"(15) EXCLUSION OF DIRECTED RECORDKEEPERS.—

"(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

1 "(B) DIRECTED RECORDKEEPER.—For
2 purposes of this paragraph, the term 'directed
3 recordkeeper' means, in connection with a
4 group health plan, a person engaged in directed
5 recordkeeping activities pursuant to the specific
6 instructions of the plan or the employer or
7 other plan sponsor, including the distribution of
8 enrollment information and distribution of dis-
9 closure materials under this Act or subtitle A
10 of the Bipartisan Patient Protection Act and
11 whose duties do not include making decisions
12 on claims for benefits.
13 "(C) LIMITATION.—Subparagraph (A)
14 does not apply in connection with any directed
15 recordkeeper to the extent that the directed rec-
16 ordkeeper fails to follow the specific instruction
17 of the plan or the employer or other plan spon-
18 sor.
19 "(16) EXCLUSION OF HEALTH INSURANCE
20 AGENTS.—Paragraph (1) does not apply with re-
21 spect to a person whose sole involvement with the
22 group health plan is providing advice or administra-
23 tive services to the employer or other plan sponsor
24 relating to the selection of health insurance coverage
25 offered in connection with the plan.

"(17) NO EFFECT ON STATE LAW.—No provision of State law (as defined in section 514(c)(1)) shall be treated as superseded or otherwise altered, amended, modified, invalidated, or impaired by reason of the provisions of subsection (a)(1)(C) and this subsection.

"(18) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

"(A) IN GENERAL.—Notwithstanding the direct participation (as defined in paragraph (5)(C)(i)) of an employer or plan sponsor, in any case in which there is (or is deemed under subparagraph (B) to be) a designated decisionmaker under subparagraph (B) that meets the requirements of subsection (o)(1) for an employer or other plan sponsor—

"(i) all liability of such employer or plan sponsor involved (and any employee of such employer or sponsor acting within the scope of employment) under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker, and

"(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or sponsor (or employee) in the action and may not raise any defense that the employer or sponsor (or employee) could not raise if such a decisionmaker were not so deemed.

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

"(C) TREATMENT OF CERTAIN TRUST FUNDS.—For purposes of this paragraph, the terms 'employer' and 'plan sponsor', in connection with the assumption by a designated decisionmaker of the liability of employer or other

plan sponsor pursuant to this paragraph, shall be construed to include a trust fund maintained pursuant to section 302 of the Labor Management Relations Act, 1947 (29 U.S.C. 186) or the Railway Labor Act (45 U.S.C. 151 et seq.).

"(19) PREVIOUSLY PROVIDED SERVICES.—

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

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

"(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures; or

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

"(20) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

"(A) a member of a board of directors of an employer or plan sponsor; or

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

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

"(o) REQUIREMENTS FOR DESIGNATED DECISION-MAKERS OF GROUP HEALTH PLANS.—

"(1) IN GENERAL.—For purposes of subsection (n)(18) and section 514(d)(9), a designated decision-

maker meets the requirements of this paragraph with respect to any participant or beneficiary if—

"(A) such designation is in such form as may be prescribed in regulations of the Secretary,

"(B) the designated decisionmaker—

"(i) meets the requirements of paragraph (2),

"(ii) assumes unconditionally all liability of the employer or plan sponsor involved (and any employee of such employer or sponsor acting within the scope of employment) either arising under subsection (n) or arising in a cause of action permitted under section 514(d) in connection with actions (and failures to act) of the employer or plan sponsor (or employee) occurring during the period in which the designation under subsection (n)(18) or section 514(d)(9) is in effect relating to such participant and beneficiary,

"(iii) agrees to be substituted for the employer or plan sponsor (or employee) in the action and not to raise any defense with respect to such liability that the em-

1 ployer or plan sponsor (or employee) may
2 not raise, and
3 "(iv) where paragraph (2)(B) applies,
4 assumes unconditionally the exclusive au-
5 thority under the group health plan to
6 make medically reviewable decisions under
7 the plan with respect to such participant
8 or beneficiary, and
9 "(C) the designated decisionmaker and the
10 participants and beneficiaries for whom the de-
11 cisionmaker has assumed liability are identified
12 in the written instrument required under sec-
13 tion 402(a) and as required under section
14 131(b)(19) of the Bipartisan Patient Protection
15 Act.
16 Any liability assumed by a designated decisionmaker
17 pursuant to this subsection shall be in addition to
18 any liability that it may otherwise have under appli-
19 cable law.
20 "(2) QUALIFICATIONS FOR DESIGNATED DECI-
21 SIONMAKERS.—
22 "(A) IN GENERAL.—Subject to subpara-
23 graph (B), an entity is qualified under this
24 paragraph to serve as a designated decision-
25 maker with respect to a group health plan if the

1 entity has the ability to assume the liability de-
2 scribed in paragraph (1) with respect to partici-
3 pants and beneficiaries under such plan, includ-
4 ing requirements relating to the financial obli-
5 gation for timely satisfying the assumed liabil-
6 ity, and maintains with the plan sponsor and
7 the Secretary certification of such ability. Such
8 certification shall be provided to the plan spon-
9 sor or named fiduciary and to the Secretary
10 upon designation under subsection (n)(18)(B)
11 or section 517(d)(9)(B) and not less frequently
12 than annually thereafter, or if such designation
13 constitutes a multiyear arrangement, in con-
14 junction with the renewal of the arrangement.
15 "(B) SPECIAL QUALIFICATION IN THE
16 CASE OF CERTAIN REVIEWABLE DECISIONS.—In
17 the case of a group health plan that provides
18 benefits consisting of medical care to a partici-
19 pant or beneficiary only through health insur-
20 ance coverage offered by a single health insur-
21 ance issue, such issuer is the only entity that
22 may be qualified under this paragraph to serve
23 as a designated decisionmaker with respect to
24 such participant or beneficiary, and shall serve
25 as the designated decisionmaker unless the em-

ployer or other plan sponsor acts affirmatively to prevent such service.

"(3) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of paragraph (2)(A), the requirements relating to the financial obligation of an entity for liability shall include—

"(A) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this part; or

"(B) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this part.

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

prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this paragraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

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

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

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

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

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

1 "(C) for the relief provided for in sub-
2 section (n) of this section.".
3 (b) RULES RELATING TO ERISA PREEMPTION.—
4 Section 514 of the Employee Retirement Income Security
5 Act of 1974 (29 U.S.C. 1144) is amended—
6 (1) by redesignating subsection (d) as sub-
7 section (f); and
8 (2) by inserting after subsection (c) the fol-
9 lowing new subsections:
10 "(d) PREEMPTION NOT TO APPLY TO CAUSES OF
11 ACTION UNDER STATE LAW INVOLVING MEDICALLY RE-
12 VIEWABLE DECISION.—
13 "(1) NON-PREEMPTION OF CERTAIN CAUSES OF
14 ACTION.—
15 "(A) IN GENERAL.—Except as provided in
16 this subsection, nothing in this title (including
17 section 502) shall be construed to supersede or
18 otherwise alter, amend, modify, invalidate, or
19 impair any cause of action under State law of
20 a participant or beneficiary under a group
21 health plan (or the estate of such a participant
22 or beneficiary) against the plan, the plan spon-
23 sor, any health insurance issuer offering health
24 insurance coverage in connection with the plan,
25 or any managed care entity in connection with

1 the plan to recover damages resulting from per-
2 sonal injury or for wrongful death if such cause
3 of action arises by reason of a medically review-
4 able decision.

5 "(B) MEDICALLY REVIEWABLE DECI-
6 SION.—For purposes of subparagraph (A), the
7 term 'medically reviewable decision' means a de-
8 nial of a claim for benefits under the plan
9 which is described in section 114(d)(2) of the
10 Bipartisan Patient Protection Act (relating to
11 medically reviewable decisions).

12 "(C) LIMITATION ON PUNITIVE DAM-
13 AGES.—

14 "(i) IN GENERAL.—Except as pro-
15 vided in clauses (ii) and (iii), with respect
16 to a cause of action described in subpara-
17 graph (A) brought with respect to a partic-
18 ipant or beneficiary, State law is super-
19 seded insofar as it provides any punitive,
20 exemplary, or similar damages if, as of the
21 time of the personal injury or death, all
22 the requirements of the following sections
23 of the Bipartisan Patient Protection Act
24 were satisfied with respect to the partici-
25 pant or beneficiary:

"(I) Section 112 (relating to procedures for initial claims for benefits and prior authorization determinations).

"(II) Section 113 of such Act (relating to internal appeals of claims denials).

"(III) Section 114 of such Act (relating to independent external appeals procedures).

"(ii) EXCEPTION FOR CERTAIN ACTIONS FOR WRONGFUL DEATH.—Clause (i) shall not apply with respect to an action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such an action which are only punitive or exemplary in nature.

"(iii) EXCEPTION FOR WILLFUL OR WANTON DISREGARD FOR THE RIGHTS OR SAFETY OF OTHERS.—Clause (i) shall not apply with respect to any cause of action described in subparagraph (A) if, in such action, the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with willful or

wanton disregard for the rights or safety of others was a proximate cause of the personal injury or wrongful death that is the subject of the action.

"(2) DEFINITIONS AND RELATED RULES.—For purposes of this subsection and subsection (e)—

"(A) TREATMENT OF EXCEPTED BENEFITS.—Under section 154(a) of the Bipartisan Patient Protection Act, the provisions of this subsection do not apply to certain excepted benefits.

"(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

"(C) CLAIM FOR BENEFIT; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' shall have the meaning provided such terms under section 112(e) of the Bipartisan Patient Protection Act.

"(D) MANAGED CARE ENTITY.—

"(i) IN GENERAL.—The term 'managed care entity' means, in connection with a group health plan and subject to clause (ii), any entity that is involved in deter-

1 mining the manner in which or the extent
2 to which items or services (or reimburse-
3 ment therefor) are to be provided as bene-
4 fits under the plan.

5 "(ii) TREATMENT OF TREATING PHY-
6 SICIANS, OTHER TREATING HEALTH CARE
7 PROFESSIONALS, AND TREATING HOS-
8 PITALS.—Such term does not include a
9 treating physician or other treating health
10 care professional (as defined in section
11 502(n)(6)(B)(i)) of the participant or ben-
12 eficiary and also does not include a treat-
13 ing hospital insofar as it is acting solely in
14 the capacity of providing treatment or care
15 to the participant or beneficiary. Nothing
16 in the preceding sentence shall be con-
17 strued to preempt vicarious liability of any
18 plan, plan sponsor, health insurance issuer,
19 or managed care entity.

20 "(E) GROUP HEALTH PLAN AND OTHER
21 RELATED TERMS.—The provisions of sections
22 732(d) and 733 apply for purposes of this sub-
23 section in the same manner as they apply for
24 purposes of part 7, except that the term 'group

1 health plan' includes a group health plan (as
2 defined in section 607(1)).
3 "(3) EXCLUSION OF EMPLOYERS AND OTHER
4 PLAN SPONSORS.—
5 "(A) CAUSES OF ACTION AGAINST EM-
6 PLOYERS AND PLAN SPONSORS PRECLUDED.—
7 Subject to subparagraph (B), paragraph (1)
8 does not apply with respect to—
9 "(i) any cause of action against an
10 employer or other plan sponsor maintain-
11 ing the plan (or against an employee of
12 such an employer or sponsor acting within
13 the scope of employment), or
14 "(ii) a right of recovery, indemnity, or
15 contribution by a person against an em-
16 ployer or other plan sponsor (or such an
17 employee) for damages assessed against
18 the person pursuant to a cause of action to
19 which paragraph (1) applies.
20 "(B) CERTAIN CAUSES OF ACTION PER-
21 MITTED.—Notwithstanding subparagraph (A),
22 paragraph (1) applies with respect to any cause
23 of action that is brought by a participant or
24 beneficiary under a group health plan (or the
25 estate of such a participant or beneficiary) to

1 recover damages resulting from personal injury
2 or for wrongful death against any employer or
3 other plan sponsor maintaining the plan (or
4 against an employee of such an employer or
5 sponsor acting within the scope of employment)
6 if such cause of action arises by reason of a
7 medically reviewable decision, to the extent that
8 there was direct participation by the employer
9 or other plan sponsor (or employee) in the deci-
10 sion.

11 ''(C) DIRECT PARTICIPATION.—

12 ''(i) DIRECT PARTICIPATION IN DECI-
13 SIONS.—For purposes of subparagraph
14 (B), the term 'direct participation' means,
15 in connection with a decision described in
16 subparagraph (B), the actual making of
17 such decision or the actual exercise of con-
18 trol in making such decision or in the con-
19 duct constituting the failure.

20 ''(ii) RULES OF CONSTRUCTION.—For
21 purposes of clause (i), the employer or plan
22 sponsor (or employee) shall not be con-
23 strued to be engaged in direct participation
24 because of any form of decisionmaking or
25 other conduct that is merely collateral or

1 precedent to the decision described in sub-
2 paragraph (B) on a particular claim for
3 benefits of a particular participant or bene-
4 ficiary, including (but not limited to)—
5 ''(I) any participation by the em-
6 ployer or other plan sponsor (or em-
7 ployee) in the selection of the group
8 health plan or health insurance cov-
9 erage involved or the third party ad-
10 ministrator or other agent;
11 ''(II) any engagement by the em-
12 ployer or other plan sponsor (or em-
13 ployee) in any cost-benefit analysis
14 undertaken in connection with the se-
15 lection of, or continued maintenance
16 of, the plan or coverage involved;
17 ''(III) any participation by the
18 employer or other plan sponsor (or
19 employee) in the process of creating,
20 continuing, modifying, or terminating
21 the plan or any benefit under the
22 plan, if such process was not substan-
23 tially focused solely on the particular
24 situation of the participant or bene-

1 ficiary referred to in paragraph
2 (1)(A); and
3 ''(IV) any participation by the
4 employer or other plan sponsor (or
5 employee) in the design of any benefit
6 under the plan, including the amount
7 of copayment and limits connected
8 with such benefit.
9 ''(iv) IRRELEVANCE OF CERTAIN COL-
10 LATERAL EFFORTS MADE BY EMPLOYER
11 OR PLAN SPONSOR.—For purposes of this
12 subparagraph, an employer or plan sponsor
13 shall not be treated as engaged in direct
14 participation in a decision with respect to
15 any claim for benefits or denial thereof in
16 the case of any particular participant or
17 beneficiary solely by reason of—
18 ''(I) any efforts that may have
19 been made by the employer or plan
20 sponsor to advocate for authorization
21 of coverage for that or any other par-
22 ticipant or beneficiary (or any group
23 of participants or beneficiaries), or
24 ''(II) any provision that may
25 have been made by the employer or

1 plan sponsor for benefits which are
2 not covered under the terms and con-
3 ditions of the plan for that or any
4 other participant or beneficiary (or
5 any group of participants or bene-
6 ficiaries).

7 "(4) REQUIREMENT OF EXHAUSTION.—

8 "(A) IN GENERAL.—Except as provided in
9 subparagraph (D), a cause of action may not be
10 brought under paragraph (1) in connection with
11 any denial of a claim for benefits of any indi-
12 vidual until all administrative processes under
13 sections 112, 113, and 114 of the Bipartisan
14 Patient Protection Act (if applicable) have been
15 exhausted.

16 "(B) LATE MANIFESTATION OF INJURY.—

17 "(i) IN GENERAL.—A participant or
18 beneficiary shall not be precluded from
19 pursuing a review under section 114 of the
20 Bipartisan Patient Protection Act regard-
21 ing an injury that such participant or ben-
22 eficiary has experienced if the external re-
23 view entity first determines that the injury
24 of such participant or beneficiary is a late
25 manifestation of an earlier injury.

1 "(ii) DEFINITION.—In this subpara-
2 graph, the term 'late manifestation of an
3 earlier injury' means an injury sustained
4 by the participant or beneficiary which was
5 not known, and should not have been
6 known, by such participant or beneficiary
7 by the latest date that the requirements of
8 subparagraph (A) should have been met
9 regarding the claim for benefits which was
10 denied.
11 "(C) EXCEPTION FOR NEEDED CARE.—A
12 participant or beneficiary may seek relief exclu-
13 sively in Federal court under subsection
14 502(a)(1)(B) prior to the exhaustion of admin-
15 istrative remedies under sections 112, 113, or
16 114 of the Bipartisan Patient Protection Act
17 (as required under subparagraph (A)) if it is
18 demonstrated to the court that the exhaustion
19 of such remedies would cause irreparable harm
20 to the health of the participant or beneficiary.
21 Notwithstanding the awarding of relief under
22 subsection 502(a)(1)(B) pursuant to this sub-
23 paragraph, no relief shall be available as a re-
24 sult of, or arising under, paragraph (1)(A) un-

less the requirements of subparagraph (A) are met.

"(D) FAILURE TO REVIEW.—

"(i) IN GENERAL.—If the external review entity fails to make a determination within the time required under section 114(e)(1)(A)(i), a participant or beneficiary may bring an action under section 514(d) after 10 additional days after the date on which such time period has expired and the filing of such action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to section 114(e)(1)(A)(i).

"(ii) EXPEDITED DETERMINATION.—If the external review entity fails to make a determination within the time required under section 114(e)(1)(A)(ii), a participant or beneficiary may bring an action under this subsection and the filing of such an action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to section 114(e)(1)(A)(ii).

"(E) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

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

"(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

"(F) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 114 of the Bipartisan Patient Protection Act shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

"(5) TOLLING PROVISION.—The statute of limitations for any cause of action arising under section 502(n) relating to a denial of a claim for benefits that is the subject of an action brought in State court shall be tolled until such time as the State court makes a final disposition, including all ap-

1 peals, of whether such claim should properly be
2 within the jurisdiction of the State court. The tolling
3 period shall be determined by the applicable Federal
4 or State law, whichever period is greater.

5 "(6) EXCLUSION OF DIRECTED RECORD-
6 KEEPERS.—

7 "(A) IN GENERAL.—Subject to subpara-
8 graph (C), paragraph (1) shall not apply with
9 respect to a directed recordkeeper in connection
10 with a group health plan.

11 "(B) DIRECTED RECORDKEEPER.—For
12 purposes of this paragraph, the term 'directed
13 recordkeeper' means, in connection with a
14 group health plan, a person engaged in directed
15 recordkeeping activities pursuant to the specific
16 instructions of the plan or the employer or
17 other plan sponsor, including the distribution of
18 enrollment information and distribution of dis-
19 closure materials under this Act or subtitle A of
20 the Bipartisan Patient Protection Act and
21 whose duties do not include making decisions
22 on claims for benefits.

23 "(C) LIMITATION.—Subparagraph (A)
24 does not apply in connection with any directed
25 recordkeeper to the extent that the directed rec-

ordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

"(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) saving from preemption a cause of action under State law for the failure to provide a benefit for an item or service which is specifically excluded under the group health plan involved, except to the extent that—

"(i) the application or interpretation of the exclusion involves a determination described in section 114(d)(2) of the Bipartisan Patient Protection Act, or

"(ii) the provision of the benefit for the item or service is required under Federal law or under applicable State law consistent with subsection (b)(2)(B);

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

"(C) affecting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as de-

fined in section 733(c)), other than those described in section 733(c)(2)(A); or

"(D) affecting a cause of action under State law other than a cause of action described in paragraph (1)(A).

"(8) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action described in paragraph (1)(A).

"(9) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

"(A) IN GENERAL.—Paragraph (1) shall not apply with respect to any cause of action described in paragraph (1)(A) under State law insofar as such cause of action provides for liability with respect to a participant or beneficiary of an employer or plan sponsor (or an employee of such employer or sponsor acting within the scope of employment), if with respect to the employer or plan sponsor there is (or is deemed under subparagraph (B) to be) a designated decisionmaker that meets the require-

ments of section 502(o)(1) with respect to such participant or beneficiary. Such paragraph (1) shall apply with respect to any cause of action described in paragraph (1)(A) under State law against the designated decisionmaker of such employer or other plan sponsor with respect to the participant or beneficiary.

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

"(C) TREATMENT OF CERTAIN TRUST FUNDS.—For purposes of this paragraph, the terms 'employer' and 'plan sponsor', in connection with the assumption by a designated decisionmaker of the liability of employer or other

plan sponsor pursuant to this paragraph, shall be construed to include a trust fund maintained pursuant to section 302 of the Labor Management Relations Act, 1947 (29 U.S.C. 186) or the Railway Labor Act (45 U.S.C. 151 et seq.).

"(10) PREVIOUSLY PROVIDED SERVICES.—

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

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

"(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

"(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

"(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

"(11) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

"(A) a member of a board of directors of an employer or plan sponsor; or

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

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

"(12) CHOICE OF LAW.—A cause of action brought under paragraph (1) shall be governed by the law (including choice of law rules) of the State in which the plaintiff resides.

"(13) LIMITATION ON ATTORNEYS' FEES.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney's fee, the amount of an attorney's contingency fee allowable for a cause of action brought under paragraph (1) shall not exceed ⅓ of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

"(B) DETERMINATION BY COURT.—The last court in which the action was pending upon the final disposition, including all appeals, of the action may review the attorney's fee to ensure that the fee is a reasonable one.

"(C) NO PREEMPTION OF STATE LAW.—Subparagraph (A) shall not apply with respect to a cause of action under paragraph (1) that is brought in a State that has a law or framework of laws with respect to the amount of an attorney's contingency fee that may be incurred

for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings such a cause of action.

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

"(1) affecting any State law relating to the practice of medicine or the provision of, or the failure to provide, medical care, or affecting any action (whether the liability is direct or vicarious) based upon such a State law,

"(2) superseding any State law permitted under section 152(b)(1)(A) of the Bipartisan Patient Protection Act, or

"(3) affecting any applicable State law with respect to limitations on monetary damages.

"(f) NO RIGHT OF ACTION FOR RECOVERY, INDEMNITY, OR CONTRIBUTION BY ISSUERS AGAINST TREATING HEALTH CARE PROFESSIONALS AND TREATING HOSPITALS.—In the case of any care provided, or any treatment decision made, by the treating health care professional or the treating hospital of a participant or beneficiary under a group health plan which consists of medical care provided under such plan, any cause of action under State law against the treating health care professional or

the treating hospital by the plan or a health insurance issuer providing health insurance coverage in connection with the plan for recovery, indemnity, or contribution in connection with such care (or any medically reviewable decision made in connection with such care) or such treatment decision is superseded.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the applicable effective under section 181.

SEC. 173. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 172, is further amended by adding at the end the following:

''(p) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under subsection (n) or (o) in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is lim-

ited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

"(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2004.".

SEC. 174. LIMITATIONS ON ACTIONS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 172(a)) is amended further by adding at the end the following new subsection:

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

"(1) IN GENERAL.—Except as provided in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 111, chapter 2, or chap-

ter 4 of subtitle A of the Bipartisan Patient Protection Act (as incorporated under section 714).

"(2) CERTAIN ACTIONS ALLOWABLE.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 111, 123, 124, 125, 126, 127, 128(a)(3), 129, or 130 of the Bipartisan Patient Protection Act (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

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

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

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

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

SEC. 175. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

"SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

"(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent con-

sistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

SEC. 176. SENSE OF THE SENATE CONCERNING THE IMPORTANCE OF CERTAIN UNPAID SERVICES.

It is the sense of the Senate that the court should consider the loss of a nonwage earning spouse or parent as an economic loss for the purposes of this section. Furthermore, the court should define the compensation for the loss not as minimum services, but, rather, in terms that fully compensate for the true and whole replacement cost to the family.

Subtitle D—Effective Dates; Coordination in Implementation

SEC. 181. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (d), the amendments made by sections 161(a), 171, and 173 (and subtitle A insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 2003 (in this section referred to as the ''general effective date'').

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 161(a), 171, and 173 (and subtitle A insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (excluding any extension thereof agreed to after the date of the enactment of this Act); or

(B) the general effective date;

but shall apply not later than 1 year after the general effective date. For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this title shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Subject to subsection (d), the amendments made by section 162 shall apply with respect to individual health in-

1 surance coverage offered, sold, issued, renewed, in effect,
2 or operated in the individual market on or after the gen-
3 eral effective date.

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

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

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

12 (B) require such plans or issuers to—

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

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

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

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

1 insurance coverage for treatment by a reli-
2 gious nonmedical provider; or
3 (C) require such plans or issuers to ex-
4 clude religious nonmedical providers because
5 they do not provide medical or other required
6 data, if such data is inconsistent with the reli-
7 gious nonmedical treatment or nursing care
8 provided by the provider.
9 (2) RELIGIOUS NONMEDICAL PROVIDER.—For
10 purposes of this subsection, the term ''religious non-
11 medical provider'' means a provider who provides no
12 medical care but who provides only religious non-
13 medical treatment or religious nonmedical nursing
14 care.
15 (d) TRANSITION FOR NOTICE REQUIREMENT.—The
16 disclosure of information required under section 131 of
17 this title shall first be provided pursuant to—
18 (1) subsection (a) with respect to a group
19 health plan that is maintained as of the general ef-
20 fective date, not later than 30 days before the begin-
21 ning of the first plan year to which subtitle A ap-
22 plies in connection with the plan under such sub-
23 section; or
24 (2) subsection (b) with respect to a individual
25 health insurance coverage that is in effect as of the

general effective date, not later than 30 days before the first date as of which subtitle A applies to the coverage under such subsection.

SEC. 182. COORDINATION IN IMPLEMENTATION.

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

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

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

SEC. 183. SEVERABILITY.

If any provision of this title, an amendment made by this title, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this title, the amendments made by this title, and the application of the provisions of such

to any person or circumstance shall not be affected thereby.

Subtitle E—Miscellaneous Provisions

SEC. 191. NO IMPACT ON SOCIAL SECURITY TRUST FUND.

(a) IN GENERAL.—Nothing in this title (or an amendment made by this title) shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(b) TRANSFERS.—

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

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

of such trust funds are not reduced as a result of the enactment of such Act.

SEC. 192. CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking "2003" and inserting "2011, except that fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006".

SEC. 193. FISCAL YEAR 2003 MEDICARE PAYMENTS.

Notwithstanding any other provision of law, any letter of credit under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that would otherwise be sent to the Treasury or the Federal Reserve Board on September 30, 2003, by a carrier with a contract under section 1842 of that Act (42 U.S.C. 1395u) shall be sent on October 1, 2003.

SEC. 194. SENSE OF SENATE WITH RESPECT TO PARTICIPATION IN CLINICAL TRIALS AND ACCESS TO SPECIALTY CARE.

(a) FINDINGS.—The Senate finds the following:

(1) Breast cancer is the most common form of cancer among women, excluding skin cancers.

(2) During 2001, 182,800 new cases of female invasive breast cancer will be diagnosed, and 40,800 women will die from the disease.

(3) In addition, 1,400 male breast cancer cases are projected to be diagnosed, and 400 men will die from the disease.

(4) Breast cancer is the second leading cause of cancer death among all women and the leading cause of cancer death among women between ages 40 and 55.

(5) This year 8,600 children are expected to be diagnosed with cancer.

(6) 1,500 children are expected to die from cancer this year.

(7) There are approximately 333,000 people diagnosed with multiple sclerosis in the United States and 200 more cases are diagnosed each week.

(8) Parkinson's disease is a progressive disorder of the central nervous system affecting 1,000,000 in the United States.

(9) An estimated 198,100 men will be diagnosed with prostate cancer this year.

(10) 31,500 men will die from prostate cancer this year. It is the second leading cause of cancer in men.

(11) While information obtained from clinical trials is essential to finding cures for diseases, it is still research which carries the risk of fatal results.

Future efforts should be taken to protect the health and safety of adults and children who enroll in clinical trials.

(12) While employers and health plans should be responsible for covering the routine costs associated with federally approved or funded clinical trials, such employers and health plans should not be held legally responsible for the design, implementation, or outcome of such clinical trials, consistent with any applicable State or Federal liability statutes.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) men and women battling life-threatening, deadly diseases, including advanced breast or ovarian cancer, should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician;

(2) an individual should have the opportunity to participate in a federally approved or funded clinical trial recommended by their physician if—

(A) that individual—

(i) has a life-threatening or serious illness for which no standard treatment is effective;

(ii) is eligible to participate in a federally approved or funded clinical trial according to the trial protocol with respect to treatment of the illness;

(B) that individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual; and

(C) either—

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

(ii) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A);

(3) a child with a life-threatening illness, including cancer, should be allowed to participate in a federally approved or funded clinical trial if that

1 participation meets the requirements of paragraph
2 (2);
3 (4) a child with a rare cancer should be allowed
4 to go to a cancer center capable of providing high
5 quality care for that disease; and
6 (5) a health maintenance organization's deci-
7 sion that an in-network physician without the nec-
8 essary expertise can provide care for a seriously ill
9 patient, including a woman battling cancer, should
10 be appealable to an independent, impartial body, and
11 that this same right should be available to all Ameri-
12 cans in need of access to high quality specialty care.

13 **SEC. 195. SENSE OF THE SENATE REGARDING FAIR REVIEW**
14 **PROCESS.**

15 (a) FINDINGS.—The Senate finds the following:
16 (1) A fair, timely, impartial independent exter-
17 nal appeals process is essential to any meaningful
18 program of patient protection.
19 (2) The independence and objectivity of the re-
20 view organization and review process must be en-
21 sured.
22 (3) It is incompatible with a fair and inde-
23 pendent appeals process to allow a health mainte-
24 nance organization to select the review organization

that is entrusted with providing a neutral and unbiased medical review.

(4) The American Arbitration Association and arbitration standards adopted under chapter 44 of title 28, United States Code (28 U.S.C. 651 et seq.) both prohibit, as inherently unfair, the right of one party to a dispute to choose the judge in that dispute.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) every patient who is denied care by a health maintenance organization or other health insurance company should be entitled to a fair, speedy, impartial appeal to a review organization that has not been selected by the health plan;

(2) the States should be empowered to maintain and develop the appropriate process for selection of the independent external review entity;

(3) a child battling a rare cancer whose health maintenance organization has denied a covered treatment recommended by its physician should be entitled to a fair and impartial external appeal to a review organization that has not been chosen by the organization or plan that has denied the care; and

(4) patient protection legislation should not preempt existing State laws in States where there already are strong laws in place regarding the selection of independent review organizations.

SEC. 196. ANNUAL REVIEW.

(a) IN GENERAL.—Not later than 24 months after the general effective date referred to in section 181(a)(1), and annually thereafter for each of the succeeding 4 calendar years (or until a repeal is effective under subsection (b)), the Secretary of Health and Human Services shall request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this title, and the amendments made by this title, on the number of individuals in the United States with health insurance coverage.

(b) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 2004 and 2005, the Secretary of Health and Human Services shall provide for such funding as the Secretary determines necessary for the conduct of the study of the National Academy of Sciences under this section.

TITLE II—MENTAL HEALTH PARITY

SEC. 201. SHORT TITLE.

This title may be cited as the ''Mental Health Equitable Treatment Act of 2003''.

SEC. 202. AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended to read as follows:

''SEC. 712. MENTAL HEALTH PARITY.

''(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not impose any treatment limitations or financial requirements with respect to the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits.

''(b) CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection

1 with such a plan) to provide any mental health bene-
2 fits.
3 "(2) MEDICAL MANAGEMENT OF MENTAL
4 HEALTH BENEFITS.—Consistent with subsection (a),
5 nothing in this section shall be construed to prevent
6 the medical management of mental health benefits,
7 including through concurrent and retrospective utili-
8 zation review and utilization management practices,
9 preauthorization, and the application of medical ne-
10 cessity and appropriateness criteria applicable to be-
11 havioral health and the contracting and use of a net-
12 work of participating providers.
13 "(3) NO REQUIREMENT OF SPECIFIC SERV-
14 ICES.—Nothing in this section shall be construed as
15 requiring a group health plan (or health insurance
16 coverage offered in connection with such a plan) to
17 provide coverage for specific mental health services,
18 except to the extent that the failure to cover such
19 services would result in a disparity between the cov-
20 erage of mental health and medical and surgical
21 benefits.
22 "(c) SMALL EMPLOYER EXEMPTION.—
23 "(1) IN GENERAL.—This section shall not apply
24 to any group health plan (and group health insur-
25 ance coverage offered in connection with a group

health plan) for any plan year of any employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year.

"(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

"(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

"(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

1 "(d) SEPARATE APPLICATION TO EACH OPTION OF-
2 FERED.—In the case of a group health plan that offers
3 a participant or beneficiary two or more benefit package
4 options under the plan, the requirements of this section
5 shall be applied separately with respect to each such op-
6 tion.

7 "(e) IN-NETWORK AND OUT-OF-NETWORK RULES.—
8 In the case of a plan or coverage option that provides in-
9 network mental health benefits, out-of-network mental
10 health benefits may be provided using treatment limita-
11 tions or financial requirements that are not comparable
12 to the limitations and requirements applied to medical and
13 surgical benefits if the plan or coverage provides such in-
14 network mental health benefits in accordance with sub-
15 section (a) and provides reasonable access to in-network
16 providers and facilities.

17 "(f) DEFINITIONS.—For purposes of this section—

18 "(1) FINANCIAL REQUIREMENTS.—The term
19 'financial requirements' includes deductibles, coin-
20 surance, co-payments, other cost sharing, and limita-
21 tions on the total amount that may be paid by a
22 participant or beneficiary with respect to benefits
23 under the plan or health insurance coverage and
24 shall include the application of annual and lifetime
25 limits.

1 "(2) MEDICAL OR SURGICAL BENEFITS.—The
2 term 'medical or surgical benefits' means benefits
3 with respect to medical or surgical services, as de-
4 fined under the terms of the plan or coverage (as the
5 case may be), but does not include mental health
6 benefits.
7 "(3) MENTAL HEALTH BENEFITS.—The term
8 'mental health benefits' means benefits with respect
9 to services, as defined under the terms and condi-
10 tions of the plan or coverage (as the case may be),
11 for all categories of mental health conditions listed
12 in the Diagnostic and Statistical Manual of Mental
13 Disorders, Fourth Edition (DSM IV–TR), or the
14 most recent edition if different than the Fourth Edi-
15 tion, if such services are included as part of an au-
16 thorized treatment plan that is in accordance with
17 standard protocols and such services meet the plan
18 or issuer's medical necessity criteria. Such term does
19 not include benefits with respect to the treatment of
20 substance abuse or chemical dependency.
21 "(4) TREATMENT LIMITATIONS.—The term
22 'treatment limitations' means limitations on the fre-
23 quency of treatment, number of visits or days of cov-
24 erage, or other similar limits on the duration or
25 scope of treatment under the plan or coverage.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to plan years beginning on or after January 1, 2004.

SEC. 203. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Section 2705 of the Public Health Service Act (42 U.S.C. 300gg–5) is amended to read as follows:

"SEC. 2705. MENTAL HEALTH PARITY.

"(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not impose any treatment limitations or financial requirements with respect to the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits.

"(b) CONSTRUCTION.—

"(1) IN GENERAL.—Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

1 "(2) MEDICAL MANAGEMENT OF MENTAL
2 HEALTH BENEFITS.—Consistent with subsection (a),
3 nothing in this section shall be construed to prevent
4 the medical management of mental health benefits,
5 including through concurrent and retrospective utili-
6 zation review and utilization management practices,
7 preauthorization, and the application of medical ne-
8 cessity and appropriateness criteria applicable to be-
9 havioral health and the contracting and use of a net-
10 work of participating providers.
11 "(3) NO REQUIREMENT OF SPECIFIC SERV-
12 ICES.—Nothing in this section shall be construed as
13 requiring a group health plan (or health insurance
14 coverage offered in connection with such a plan) to
15 provide coverage for specific mental health services,
16 except to the extent that the failure to cover such
17 services would result in a disparity between the cov-
18 erage of mental health and medical and surgical
19 benefits.
20 "(c) SMALL EMPLOYER EXEMPTION.—
21 "(1) IN GENERAL.—This section shall not apply
22 to any group health plan (and group health insur-
23 ance coverage offered in connection with a group
24 health plan) for any plan year of any employer who
25 employed an average of at least 2 but not more than

50 employees on business days during the preceding calendar year.

"(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

"(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

"(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers

1 a participant or beneficiary two or more benefit package
2 options under the plan, the requirements of this section
3 shall be applied separately with respect to each such op-
4 tion.

5 "(e) IN-NETWORK AND OUT-OF-NETWORK RULES.—
6 In the case of a plan or coverage option that provides in-
7 network mental health benefits, out-of-network mental
8 health benefits may be provided using treatment limita-
9 tions or financial requirements that are not comparable
10 to the limitations and requirements applied to medical and
11 surgical benefits if the plan or coverage provides such in-
12 network mental health benefits in accordance with sub-
13 section (a) and provides reasonable access to in-network
14 providers and facilities.

15 "(f) DEFINITIONS.—For purposes of this section—

16 "(1) FINANCIAL REQUIREMENTS.—The term
17 'financial requirements' includes deductibles, coin-
18 surance, co-payments, other cost sharing, and limita-
19 tions on the total amount that may be paid by a
20 participant, beneficiary or enrollee with respect to
21 benefits under the plan or health insurance coverage
22 and shall include the application of annual and life-
23 time limits.

24 "(2) MEDICAL OR SURGICAL BENEFITS.—The
25 term 'medical or surgical benefits' means benefits

with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

"(3) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV–TR), or the most recent edition if different than the Fourth Edition, if such services are included as part of an authorized treatment plan that is in accordance with standard protocols and such services meet the plan or issuer's medical necessity criteria. Such term does not include benefits with respect to the treatment of substance abuse or chemical dependency.

"(4) TREATMENT LIMITATIONS.—The term 'treatment limitations' means limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment under the plan or coverage.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to plan years beginning on or after January 1, 2004.

SEC. 204. PREEMPTION.

Nothing in the amendments made by this title shall be construed to preempt any provision of State law, with respect to health insurance coverage offered by a health insurance issuer in connection with a group health plan, that provides protections to enrollees that are greater than the protections provided under such amendments. Nothing in the amendments made by this title shall be construed to affect or modify section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 205. GENERAL ACCOUNTING OFFICE STUDY.

(a) STUDY.—The Comptroller General shall conduct a study that evaluates the effect of the implementation of the amendments made by this title on the cost of health insurance coverage, access to health insurance coverage (including the availability of in-network providers), the quality of health care, and other issues as determined appropriate by the Comptroller General.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall prepare and submit to the appropriate committees of Con-

gress a report containing the results of the study conducted under subsection (a).

TITLE III—PATIENT SAFETY

SEC. 301. SHORT TITLE.

This title may be cited as the ''Patient Safety Improvement and Medical Injury Reduction Act''.

SEC. 302. PURPOSE.

It is the purpose of this title to improve patient safety by promoting the voluntary reporting of patient safety events and medical errors and other measures.

SEC. 303. PATIENT SAFETY IMPROVEMENTS.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) in section 912(c), by inserting '', in accordance with part C,'' after ''The Director shall'';

(2) by redesignating part C as part E;

(3) by redesignating sections 921 through 928, as sections 941 through 948, respectively;

(4) in section 948(1) (as so redesignated), by striking ''921'' and inserting ''941''; and

(5) by inserting after part B the following:

''PART C—PATIENT SAFETY IMPROVEMENT

''SEC. 921. DEFINITIONS.

''In this part:

1 "(1) CENTER.—The term 'Center' means the
2 Center for Quality Improvement and Patient Safety
3 established under section 922(a).
4 "(2) HEALTH CARE PROVIDER.—The term
5 'health care provider' means an individual or entity
6 licensed or otherwise authorized under State law to
7 provide health care services, including—
8 "(A) a hospital, nursing facility, com-
9 prehensive outpatient rehabilitation facility,
10 home health agency, and hospice program;
11 "(B) a physician, physician assistant,
12 nurse practitioner, clinical nurse specialist,
13 nurse anesthetist, certified nurse midwife, psy-
14 chologist, certified social worker, registered die-
15 titian or nutrition professional, physical or oc-
16 cupational therapist, or other individual health
17 care practitioner;
18 "(C) a pharmacist; and
19 "(D) a renal dialysis facility, ambulatory
20 surgical center, pharmacy, physician or health
21 care practitioner's office, long-term care facility,
22 behavioral health residential treatment facility,
23 clinical laboratory, or community health center.
24 "(3) IDENTIFIABLE INFORMATION.—The term
25 'identifiable information' means information that is

1 presented in a form and manner that allows the
2 identification of any health care provider, patient, or
3 reporter of patient safety information. With respect
4 to patients, such information includes any individ-
5 ually identifiable health information as that term is
6 defined in the regulations promulgated pursuant to
7 section 264(c) of the Health Insurance Portability
8 and Accountability Act of 1996 (Public Law 104–
9 191; 110 Stat. 2033).

10 "(4) NATIONAL PATIENT SAFETY DATABASE.—
11 The term 'National Patient Safety Database' means
12 the database of nonidentifiable information con-
13 cerning patient safety that is coordinated by, and
14 developed in collaboration with, the Director under
15 section 922(c)(3)(B).

16 "(5) NATIONAL PATIENT SAFETY RESEARCH
17 DEMONSTRATION SYSTEM.—The term 'National Pa-
18 tient Safety Research Demonstration System' means
19 a system under which the Director will enter into
20 voluntary agreements with a geographically and in-
21 stitutionally diverse group of eligible entities to col-
22 lect data for the purpose of conducting research on
23 patient safety under section 922(c)(3)(C).

24 "(6) NONIDENTIFIABLE INFORMATION.—The
25 term 'nonidentifiable information' means informa-

1 tion that is presented in a form and manner that
2 prevents the identification of any health care pro-
3 vider, patient, or reporter of patient safety informa-
4 tion. With respect to patients, such information
5 must be de-identified consistent with the regulations
6 promulgated pursuant to section 264(c) of the
7 Health Insurance Portability and Accountability Act
8 of 1996 (Public Law 104–191; 110 Stat. 2033).

9 "(7) PATIENT SAFETY INFORMATION.—The
10 term 'patient safety information' means any reports,
11 records, memoranda, analyses, deliberative work,
12 statements, or root cause analyses that are collected
13 or developed to improve patient safety or health care
14 quality and that—

15 "(A) are developed by a health care pro-
16 vider for the purpose of reporting to a patient
17 safety organization and that are reported on a
18 timely basis to such an organization; or

19 "(B) are collected or developed by a pa-
20 tient safety organization or by the National Pa-
21 tient Safety Database or National Patient Safe-
22 ty Research Demonstration System, regardless
23 of whether the information is transmitted to the
24 health care provider that reported the original
25 information.

"(8) PATIENT SAFETY ORGANIZATION.—The term 'patient safety organization' means a private or public organization, or component thereof, that is certified, through a process to be determined by the Director under section 925, to perform each of the following activities:

"(A) The conduct, as the organization or component's primary activity, of activities to improve patient safety and the quality of health care delivery.

"(B) The collection and analysis of patient safety information that is submitted by health care providers.

"(C) The development and dissemination of evidence-based information to health care providers with respect to improving patient safety (such as recommendations, protocols, or information regarding best practices).

"(D) The utilization of patient safety information to carry out activities limited to those described under this paragraph and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to health care providers to effectively minimize patient risk.

"(E) The maintenance of appropriate confidentiality with respect to identifiable information.

"(F) The provision of appropriate security measures with respect to patient safety information.

"(G) The submission of nonidentifiable information to the Agency consistent with standards established by the Director under section 924 for the National Patient Safety Database.

"SEC. 922. PRIVILEGE.

"(a) IN GENERAL.—Notwithstanding any other provision of law, patient safety information shall be privileged and confidential in accordance with this section.

"(b) SCOPE OF PRIVILEGE.—Subject to the succeeding provisions of this section, such information shall not be—

"(1) subject to a civil or administrative subpoena;

"(2) subject to discovery in connection with a civil or administrative proceeding;

"(3) disclosed pursuant to section 552 of title 5, United States Code (commonly known as the Freedom of Information Act) or any other similar Federal or State law; or

1 "(4) admitted as evidence or otherwise disclosed
2 in any Federal or State civil or administrative pro-
3 ceeding.
4 "(c) EXCEPTIONS TO PRIVILEGE.—The privilege pro-
5 vided for under this section shall not apply to—
6 "(1) records of a patient's medical diagnosis
7 and treatment, patient or hospital records, other pri-
8 mary health care information or other documents,
9 records, or data that exist separately from the proc-
10 ess of collecting or developing information for the
11 purposes of this part;
12 "(2) information merely by reason of its inclu-
13 sion, report, or the fact of its submission, to a pa-
14 tient safety organization, the National Patient Safe-
15 ty Database, or the National Patient Safety Re-
16 search Demonstration System; and
17 "(3) information available from sources other
18 than a report or submission made under this part,
19 which may be discovered or admitted in a Federal
20 or State civil or administrative proceeding, if discov-
21 erable or admissible under applicable Federal or
22 State law.
23 "(d) DISCLOSURES.—Nothing in this section shall be
24 construed to prohibit any of the following disclosures:

1 "(1) The disclosure of nonidentifiable informa-
2 tion by a health care provider, patient safety organi-
3 zation, or the Director.
4 "(2) The disclosure of identifiable information
5 by a health care provider or patient safety organiza-
6 tion, if such disclosure—
7 "(A) is authorized by the provider for the
8 purposes of improving quality and safety;
9 "(B) is to an entity or person subject to
10 the requirements of section 264(c) of the
11 Health Insurance Portability and Accountability
12 Act of 1996 (Public Law 104–191; 110 Stat.
13 2033), or any regulation promulgated under
14 such section; and
15 "(C) is not in conflict with such section or
16 any regulation promulgated under such section.
17 "(3) The disclosure of patient safety informa-
18 tion by a provider or patient safety organization to
19 the Food and Drug Administration.
20 "(e) RULES OF CONSTRUCTION.—
21 "(1) IN GENERAL.—Nothing in this section
22 shall be construed to limit or extend other privileges
23 that are available under Federal or State laws, in-
24 cluding peer review and confidentiality protections.

1 "(2) CONSTRUCTION REGARDING USE OF PA-
2 TIENT SAFETY INFORMATION.—
3 "(A) INTERNAL USE PERMITTED TO IM-
4 PROVE PATIENT SAFETY, QUALITY, AND EFFI-
5 CIENCY.—Nothing in this part shall be con-
6 strued to limit a health care provider from
7 using patient safety information within the pro-
8 vider to improve patient safety, health care
9 quality, or administrative efficiency of the pro-
10 vider.
11 "(B) TREATMENT.—Information that is
12 collected as patient safety information is not
13 disqualified from being treated as patient safety
14 information because of its use for the purposes
15 described in subparagraph (A) and such use
16 shall not constitute a waiver of any privilege or
17 protection established under this section or
18 under State law.
19 "(3) STATE MANDATORY REPORTING REQUIRE-
20 MENTS.—Nothing in this part shall be construed as
21 preempting or otherwise affecting any mandatory re-
22 porting requirement for health care providers under
23 State law.
24 "(f) APPLICATION OF PRIVACY REGULATIONS.—For
25 purposes of applying the regulations promulgated pursu-

1 ant to section 264(c) of the Health Insurance Portability
2 and Accountability Act of 1996 (Public Law 104–191; 110
3 Stat. 2033)—
4 "(1) patient safety organizations that collect or
5 receive identifiable information shall be treated as
6 covered entities; and
7 "(2) activities of such organizations described
8 in section 923(b)(2)(A) in relation to a health care
9 provider are deemed to be health care operations of
10 the provider.
11 Nothing in this section shall be construed to alter or affect
12 the implementation of such regulation or such section
13 264(c).
14 "(g) WAIVERS.—
15 "(1) IN GENERAL.—Nothing in this part shall
16 be construed as precluding a health care provider
17 from waiving the privilege established under this sec-
18 tion.
19 "(2) LIMITATION.—The disclosure of patient
20 safety information pursuant to this part shall not
21 constitute a waiver of any other Federal or State
22 privilege.
23 "(h) CONTINUATION OF PRIVILEGE.—Patient safety
24 information of an organization that is certified as a pa-
25 tient safety organization shall continue to be privileged

1 and confidential, in accordance with this section, if the or-
2 ganization's certification is terminated or revoked or if the
3 organization otherwise ceases to qualify as a patient safety
4 organization until the information is otherwise disposed of
5 in accordance with section 925(g).

6 "(i) PENALTY.—

7 "(1) PROHIBITION.—Except as provided in this
8 part, and subject to paragraph (2), it shall be un-
9 lawful for any person to disclose patient safety infor-
10 mation in violation of this section.

11 "(2) RELATION TO HIPAA.—The penalty under
12 this subsection for a disclosure described in para-
13 graph (1) shall not apply if the person making such
14 disclosure is subject to a penalty under section
15 264(c) of the Health Insurance Portability and Ac-
16 countability Act of 1996 (Public Law 104–191; 110
17 Stat. 2033), or any regulation promulgated under
18 such section, for such disclosure.

19 "(3) AMOUNT.—Any person who violates para-
20 graph (1) shall be subject to a civil monetary penalty
21 of not more than $25,000 for each such violation in-
22 volved. Such penalty shall be imposed and collected
23 in the same manner as civil money penalties are im-
24 posed and collected under subsection (a) of section
25 1128A of the Social Security Act.

1 "(j) SURVEY AND REPORT.—

2 "(1) SURVEY.—The Comptroller General of the
3 United States shall conduct a survey of State laws
4 that relate to patient safety information peer review
5 systems, including laws that establish an evidentiary
6 privilege applicable to information developed in such
7 systems, and shall review the manner in which such
8 laws have been interpreted by the courts and the ef-
9 fectiveness of such laws in promoting patient safety.

10 "(2) REPORT.—Not later than 9 months after
11 the date of enactment of this part, the Comptroller
12 General shall prepare and submit to Congress a re-
13 port concerning the results of the survey conducted
14 under paragraph (1).

15 **"SEC. 923. REPORTER PROTECTION.**

16 "(a) IN GENERAL.—A health care provider may not
17 take an adverse employment action, as described in sub-
18 section (b), against an individual based upon the fact that
19 the individual in good faith reported—

20 "(1) to the provider with the intention of hav-
21 ing it reported to a patient safety organization, or

22 "(2) directly to a patient safety organization,
23 information that would constitute patient safety informa-
24 tion if the provider were to have submitted it on a timely

1 basis to a patient safety organization in accordance with
2 this part.

3 "(b) ADVERSE EMPLOYMENT ACTION.—For pur-
4 poses of this section, an 'adverse employment action' in-
5 cludes—

6 "(1) the failure to promote an individual or pro-
7 vide any other employment-related benefit for which
8 the individual would otherwise be eligible;

9 "(2) an evaluation or decision made in relation
10 to accreditation, certification, credentialing or licens-
11 ing of the individual; and

12 "(3) a personnel action that is adverse to the
13 individual concerned.

14 "(c) REMEDIES.—The provisions of the first sentence
15 of section 1128A(a) of the Social Security Act shall apply
16 with respect to a health care provider's violation of sub-
17 section (a) in the same manner as they apply to an act
18 referred to in section 1128A(a)(7) of such Act.

19 "(d) PENALTY.—Any person who violated the provi-
20 sions of this section shall be subject to a fine of not more
21 than $25,000, imprisonment for not more than 6 months,
22 or both, per disclosure and payment of the costs of pros-
23 ecution.

"SEC. 924. CENTER FOR QUALITY IMPROVEMENT AND PATIENT SAFETY.

"(a) IN GENERAL.—The Director shall establish a center to be known as the Center for Quality Improvement and Patient Safety to carry out the duties described in subsection (b).

"(b) DUTIES.—

"(1) IN GENERAL.—The Center shall carry out the following duties:

"(A) Conduct and support research, demonstrations, and evaluations of the quality of health care and the promotion of patient safety, and the measurement of health care quality.

"(B) Develop, evaluate, and disseminate methods for identifying and promoting effective patient safety programs.

"(C) Provide for the certification and recertification of patient safety organizations in accordance with section 925.

"(D) Establish a National Patient Safety Database to collect, support, and coordinate the analysis of nonidentifiable information submitted to the Database in accordance with subsection (d).

"(E) Establish a National Patient Safety Research Demonstration System under which

1 the Director will enter into voluntary agree-
2 ments with a geographically and institutionally
3 diverse group of eligible entities to collect data
4 for the purpose of conducting research on pa-
5 tient safety.

6 "(F) Facilitate the development of con-
7 sensus, including through annual meetings,
8 among health care providers, patients, and
9 other interested parties concerning patient safe-
10 ty and recommendations to improve patient
11 safety.

12 "(G) Provide technical assistance and sup-
13 port to States that have (or are developing)
14 medical errors reporting systems, assist States
15 in developing standardized methods for data
16 collection, and collect data from State reporting
17 systems for inclusion in the National Patient
18 Safety Database.

19 "(2) CONSULTATION.—In carrying out the du-
20 ties under paragraph (1) (including the establish-
21 ment of the Database), the Director shall consult
22 with and develop partnerships, as appropriate, with
23 health care organizations, health care providers,
24 public and private sector entities, patient safety or-

1 ganizations, health care consumers, and other rel-
2 evant experts to improve patient safety.
3 "(c) IMPLEMENTATION AND CONSULTATION.—In
4 carrying out this section, the Director shall—
5 "(1) facilitate the development of patient safety
6 goals and track the progress made in meeting those
7 goals; and
8 "(2) ensure that information submitted by a
9 patient safety organization to the National Patient
10 Safety Database, as provided for under subsection
11 (d), is comparable and useful for research and anal-
12 ysis and that the research findings and patient safe-
13 ty alerts that result from such analyses are pre-
14 sented in clear and consistent formats that enhance
15 the usefulness of such alerts.
16 "(d) NATIONAL PATIENT SAFETY DATABASE.—
17 "(1) IN GENERAL.—The Director shall—
18 "(A) establish a National Patient Safety
19 Database to collect nonidentifiable information
20 concerning patient safety that is reported on a
21 voluntary basis which shall be used to analyze
22 national, regional, and State trends and pat-
23 terns in patient safety and medical errors; and
24 "(B) establish common formats for the vol-
25 untary reporting of information under subpara-

graph (A), including the establishment of necessary data elements, common and consistent definitions, and a standardized computer interface for the processing of such data.

To the extent practicable, formats established under subparagraph (A) shall be consistent with the administrative simplification provisions of part C of title XI of the Social Security Act

"(2) DATABASE.—In carrying out this subsection, the Director—

"(A) shall establish and modify as necessary criteria to determine the organizations that may voluntarily contribute to, and the data that comprises, the National Patient Safety Database;

"(B) shall ensure that the National Patient Safety Database is only used by qualified entities or individuals for purposes of research, education, and enhancing patient safety as determined appropriate by the Director in accordance with criteria applied by the Director;

"(C) may enter into contracts for the administration of the Database with private and public entities with experience in the administration of similar databases;

"(D) shall ensure that the methodologies for the collection of nonidentifiable patient safety information for the National Patient Safety Database include the methodologies developed or recommended by the Patient Safety Task Force of the Department of Health and Human Services; and

"(E) may, to the extent practicable, facilitate the direct link of information between health care providers and patient safety organizations and between patient safety organizations and the National Patient Safety Database.

"(3) NATIONAL PATIENT SAFETY RESEARCH DEMONSTRATION SYSTEM.—

"(A) ESTABLISHMENT.—

"(i) IN GENERAL.—Not later than 1 year after the date of enactment of this part, the Director shall establish a National Patient Safety Research Demonstration System under which the Director will enter into voluntary agreements with a geographically and institutionally diverse group of eligible entities to collect information for the purpose of conducting research

on patient safety. The Director may contract with other organizations to carry out this paragraph.

"(ii) PURPOSE.—The purpose of the demonstration system established under clause (i) is to conduct targeted research on patient safety and to test promising systems and methods of improving patient safety.

"(iii) NUMBER AND TYPES OF ORGANIZATIONS.—In carrying out clause (i), the Director shall determine the number and types of health care organizations with which to enter into agreements, as well as the types of patient safety events the particular health care organizations with which the Director enters into an agreement should identify and the types of analyses that such organizations should perform.

"(B) ELIGIBILITY.—To be eligible to enter into an agreement under subparagraph (A) an entity shall—

"(i) be a health care organization; and

"(ii) prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require.

"(C) SUBMISSION OF REPORTS.—

"(i) IN GENERAL.—A health care organization that enters into a voluntary agreement under subparagraph (A) shall, with respect to such organization, submit reports of patient safety events, or reports of specific types of patient safety events if so prescribed by the agreement, and shall submit, if prescribed by the agreement, root cause analyses concerning such events (using standards developed by the Director), and corrective action plans to the Director.

"(ii) PROCESSING OF INFORMATION.—The Director shall process the reports submitted under clause (i) in the same manner as reports are processed through the National Patient Safety Database.

"(iii) PROVISION OF RECOMMENDATIONS.—The Director shall provide feed-

back concerning patient safety event reports directly to the health care organizations that are participating in the demonstration system under this paragraph.

"(D) TECHNICAL ASSISTANCE.—The Director shall provide health care organizations participating in the demonstration system under this paragraph with technical support and may provide technology support, including computer software and hardware, through the patient safety improvement grants under section 932 and section 934.

"(E) EVALUATION.—Upon the expiration of the 5-year period beginning on the date on which the demonstration system is established under this paragraph, the Director shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that includes—

"(i) information on the types of data collected through the demonstration system;

1 "(ii) research conducted with data col-
2 lected through the demonstration system;
3 and
4 "(iii) the identification of promising
5 systems and methods of reducing patient
6 safety events.
7 "(F) RULE OF CONSTRUCTION.—Nothing
8 in this paragraph shall be construed to preempt
9 Federal or State mandatory reporting or sen-
10 tinel surveillance systems in effect on the date
11 of enactment of this part, or Federal or State
12 mandatory reporting or sentinel surveillance
13 systems developed after such date of enactment.
14 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated such sums as may be
16 necessary for each fiscal year to carry out this section.
17 **"SEC. 925. PATIENT SAFETY ORGANIZATIONS.**
18 "(a) CERTIFICATION AND RECERTIFICATION.—
19 "(1) IN GENERAL.—The initial certification and
20 recertification of a patient safety organization under
21 section 924 shall be made under a process that is
22 approved by the Director and is consistent with cri-
23 teria published by the Director.
24 "(2) REVOCATION.—Such a certification or re-
25 certification of a patient safety organization may be

revoked by the Director upon a showing of cause (including the disclosure of information in violation of section 922).

"(3) TERMINATION.—Such a certification provided for a patient safety organization shall terminate (subject to recertification) on the earlier of—

"(A) the date that is 3 years after the date on which such certification was provided; or

"(B) the date on which the Director revokes the certification.

"(b) ORGANIZATION REQUIREMENTS.—A patient safety organization shall meet the following criteria as conditions for certification:

"(1) The mission of the organization shall be to conduct activities to improve patient safety and the quality of health care delivery.

"(2) The organization shall collect and analyze patient safety information that is voluntarily reported by more than one health care provider on a local, regional, State, or national basis.

"(3) The organization shall have appropriately qualified staff, including licensed or certified medical professionals.

"(4) The organization is managed, controlled, and operated independently from health care pro-

1 viders that report patient safety information to it
2 under this part, and the organization—
3 "(A) does not have a material familial or
4 financial relationship (except for fees charged to
5 health care providers) with any health care pro-
6 vider from whom it receives patient safety infor-
7 mation;
8 "(B) does not otherwise have a conflict of
9 interest with such a health care provider (as de-
10 termined under regulations); and
11 "(C) is not a health insurer or other entity
12 that offers a group health plan or health insur-
13 ance coverage, or a component of such an enti-
14 ty.
15 "(5) The organization seeks to collect data from
16 health care providers in a standardized manner that
17 permits valid comparisons of similar cases among
18 similar health care providers.
19 "(6) The organization meets such other require-
20 ments as the Director may by regulation require.
21 "(c) LIMITATION ON USE OF PATIENT SAFETY IN-
22 FORMATION BY PATIENT SAFETY ORGANIZATIONS.—A
23 patient safety organization may not use patient safety in-
24 formation reported by a health care provider in accordance
25 with this part to take regulatory or enforcement actions

1 it otherwise performs (or is responsible for performing)
2 in relation to such provider.

3 "(d) TECHNICAL ASSISTANCE.—The Director may
4 provide technical assistance to patient safety organizations
5 in providing recommendations and advice to health care
6 providers reporting patient safety information under this
7 part. Such assistance shall include advice with respect to
8 methodology, communication, dissemination of informa-
9 tion, data collection, security, and confidentiality concerns.

10 "(e) COMPONENT ORGANIZATIONS.—If a patient
11 safety organization is a component of a larger organiza-
12 tion, the patient safety organization shall—

13 "(1) maintain patient safety information within
14 the component, separately from the rest of the larg-
15 er organization, and establish appropriate security
16 measures to maintain the confidentiality of the pa-
17 tient safety information;

18 "(2) not disclose patient safety information to
19 the larger organization; and

20 "(3) not create a conflict of interest with the
21 larger organization.

22 "(f) CONSTRUCTION.—Nothing in this part shall be
23 construed to limit or discourage the reporting of informa-
24 tion relating to patient safety within a health care pro-
25 vider.

1 "(g) TREATMENT OF INFORMATION.—If an organiza-
2 tion no longer qualifies as a patient safety organization
3 under this section, with respect to any patient safety infor-
4 mation that such organization received from a health care
5 provider, the organization shall comply with one of the fol-
6 lowing:

7 "(1) With the approval of the provider and an-
8 other patient safety organization, the organization
9 shall transfer such information to such other organi-
10 zation.

11 "(2) If practicable, the organization shall re-
12 turn the information to the provider.

13 "(3) The organization shall destroy the patient
14 safety information.

15 **"PART D—PATIENT SAFETY IMPROVEMENT**
16 **GRANTS**

17 **"SEC. 931. GRANTS FOR COMMUNITY PARTNERSHIPS FOR**
18 **HEALTH CARE IMPROVEMENT.**

19 "(a) IN GENERAL.—The Secretary shall award
20 grants to eligible entities to enable such entities to estab-
21 lish, enhance or improve community partnerships for
22 health care improvement among providers within a com-
23 munity for the purpose of improving the quality of medical
24 care, including the prescribing, dispensing, and use of pre-
25 scription drugs, within such community.

1 "(b) ELIGIBLE ENTITIES.—To be eligible to receive
2 a grant under subsection (a) an entity shall—
3 "(1) be a—
4 "(A) hospital;
5 "(B) health care clinic;
6 "(C) skilled nursing facility;
7 "(D) non-profit entity, or component
8 thereof, established for the purpose of estab-
9 lishing, enhancing or improving a community
10 partnership for health care improvement; or
11 "(E) consortium of any of the entities de-
12 scribed in subparagraphs (A) through (D); and
13 "(2) prepare and submit to the Secretary an
14 application at such time, in such manner, and con-
15 taining such information as the Secretary may rea-
16 sonably require, including assurances satisfactory to
17 the Secretary that the community partnership for
18 health care improvement in connection with which
19 the entity is submitting the application does, at the
20 time of application, or will, within a reasonable
21 amount of time from the date of application, include
22 the substantive participation of a broad range of en-
23 tities (that may include providers, payers, patients,
24 and governmental entities) involved in the delivery of
25 health care within the community.

1 "(c) LIMITATIONS.—In carrying out subsection (a),
2 the Secretary shall not—
3 "(1) award any single entity more than
4 $2,000,000 in any single fiscal year; or
5 "(2) award grants under this section to any sin-
6 gle entity for more than 3 fiscal years.
7 "(d) DEFINITION.—In this section, the term 'commu-
8 nity partnership for health care improvement' means a
9 formal cooperative arrangement including health care fa-
10 cilities and nonprofit organizations within a community
11 that—
12 "(1) is entered into for the purpose of signifi-
13 cantly reducing the incidence of patient safety events
14 or significantly improving the quality of health care,
15 including the appropriate use of prescription drugs,
16 at health care facilities participating in such part-
17 nership using one or more quantifiable indicators of
18 such improvement;
19 "(2) collects quantifiable data on the incidence
20 of patient safety events or on the quality of health
21 care in connection with one or more specific medical
22 procedures conducted at the health care facilities
23 participating in such partnerships;

"(3) makes available to the health care facilities participating in such partnership the data described in paragraph (2); and

"(4) promotes cooperation and communication among providers employed by the health care facilities participating in such partnership for the purposes described in paragraph (1).

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each subsequent fiscal year.

"SEC. 932. TECHNICAL STANDARDS FOR HEALTH CARE INFORMATION TECHNOLOGY SYSTEMS.

"(a) IN GENERAL.—By not later than 2 years after the date of the enactment of this part, the Secretary shall develop or adopt (and shall periodically review and update) voluntary, national standards—

"(1) that promote the interoperability of health care information technology systems across all health care settings; and

"(2) for computerized physician order entry systems, including standards relating to—

"(A) data formats or other methods of encoding medical information that facilitate transfer of data among such systems;

1 "(B) the protection of the confidentiality of
2 individually identifiable health information con-
3 tained within such systems from unauthorized
4 access or disclosure;
5 "(C) procedures for issuing warnings when
6 prescribing errors may be imminent;
7 "(D) procedures for ensuring that rec-
8 ommendations or warnings issued by such sys-
9 tems reflect good medical practice; and
10 "(E) other matters determined appropriate
11 by the Secretary.
12 "(b) COST AND INCREASED EFFICIENCY.—In pro-
13 mulgating regulations to carry out this section, the Sec-
14 retary shall take into account the cost that meeting the
15 standards under subsection (a) would have on providing
16 health care in the United States and the increased effi-
17 ciencies in providing such care achieved under the stand-
18 ards.
19 "(c) CONSULTATION AND COORDINATION.—The Sec-
20 retary shall develop and update the standards under sub-
21 section (a) in consultation with (and with coordination be-
22 tween)—
23 "(1) the National Committee for Vital and
24 Health Statistics;

"(2) the Medical Information Technology Advisory Board (established under section 933); and

"(3) the Secretary of Veterans Affairs and the Secretary of Defense.

"(d) DISSEMINATION.—The Secretary shall provide for the dissemination of the standards developed and updated under this section.

"(e) LIMITATION.—Effective beginning on the date that is 4 years after the date of enactment of this part, the Secretary may not purchase any health care information technology system unless such system conforms to the standards developed or adopted under subsection (a), to the extent that such standards have been developed or adopted.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out this section.

"SEC. 933. MEDICAL INFORMATION TECHNOLOGY ADVISORY BOARD.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than 3 months after the date of the enactment of this part, the Secretary shall appoint an advisory board to be known as the 'Medical Information Technology Advisory Board' (in this section referred to as the 'MITAB').

1 "(2) CHAIRPERSON.—The Secretary shall des-
2 ignate one member of the MITAB to serve as the
3 chairperson. The chairperson shall be an individual
4 affiliated with an organization having expertise cre-
5 ating American National Standards Institute
6 (ANSI) accepted standards in health care informa-
7 tion technology and a member of the National Com-
8 mittee for Vital and Health Statistics.
9 "(b) COMPOSITION.—
10 "(1) IN GENERAL.—The MITAB shall consist
11 of not more than 17 members that include—
12 "(A) experts from the fields of medical in-
13 formation, information technology, medical con-
14 tinuous quality improvement, medical records
15 security and privacy, individual and institu-
16 tional health care clinical providers, health re-
17 searchers, and health care purchasers;
18 "(B) one or more staff experts from each
19 of the following: the Centers for Medicare &
20 Medicaid Services, the Agency for Healthcare
21 Research and Quality, and the Institute of
22 Medicine of the National Academy of Sciences;
23 "(C) representatives of private organiza-
24 tions with expertise in medical informatics;

"(D) a representative of a teaching hospital;

"(E) one or more representatives of the health care information technology industry; and

"(F) a representative of an organization representing health care consumers.

"(2) TERMS OF APPOINTMENT.—The term of any appointment under paragraph (1) to the MITAB shall be for 2 years. Such an appointment may be renewed for one additional term.

"(3) MEETINGS.—The MITAB shall meet at the call of its chairperson or a majority of its members.

"(4) VACANCIES.—A vacancy on the MITAB shall be filled in the same manner in which the original appointment was made not later than 30 days after the MITAB is given notice of the vacancy and shall not affect the power of the remaining members to execute the duties of the MITAB.

"(5) COMPENSATION.—Members of the MITAB shall receive no additional pay, allowances, or benefits by reason of their service on the MITAB.

"(6) EXPENSES.—Each member of the MITAB shall receive travel expenses and per diem in lieu of

subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

"(c) DUTIES.—

"(1) IN GENERAL.—The MITAB shall on an ongoing basis advise, and make recommendations to, the Secretary regarding medical information technology, including the following:

"(A) The best current practices in medical information technology.

"(B) Methods for the adoption (not later than 2 years after the date of the enactment of this part) of a uniform health care information system interface between and among old and new computer systems.

"(C) Recommendations for health care vocabulary, messaging, and other technology standards (including a common lexicon for computer technology) necessary to achieve the interoperability of health care information systems for the purposes described in subparagraph (E).

"(D) Methods of implementing—

"(i) health care information technology interoperability standardization; and

1 "(ii) records security.
2 "(E) Methods to promote information ex-
3 change among health care providers so that
4 long-term compatibility among information sys-
5 tems is maximized, in order to do one or more
6 of the following:
7 "(i) To maximize positive outcomes in
8 clinical care—
9 "(I) by providing decision sup-
10 port for diagnosis and care; and
11 "(II) by assisting in the emer-
12 gency treatment of a patient pre-
13 senting at a facility where there is no
14 medical record for the patient.
15 "(ii) To contribute to (and be con-
16 sistent with) the development of the pa-
17 tient assessment instrument provided for
18 under section 545 of the Medicare, Med-
19 icaid, and SCHIP Benefits Improvement
20 and Protection Act of 2000, and to assist
21 in minimizing the need for new and dif-
22 ferent records as patients move from pro-
23 vider to provider.
24 "(iii) To reduce or eliminate the need
25 for redundant records, paperwork, and the

1 repetitive taking of patient histories and
2 administering of tests.
3 "(iv) To minimize medical errors,
4 such as administration of contraindicated
5 drugs.
6 "(v) To provide a compatible informa-
7 tion technology architecture that facilitates
8 future quality and cost-saving needs and
9 that avoids the financing and development
10 of information technology systems that are
11 not readily compatible.
12 "(2) REPORTS.—
13 "(A) INITIAL REPORT.—Not later than 18
14 months after the date of the enactment of this
15 part, the MITAB shall submit to Congress and
16 the Secretary an initial report concerning the
17 matters described in paragraph (1). The report
18 shall include—
19 "(i) the practices described in para-
20 graph (1)(A), including the status of
21 health care information technology stand-
22 ards being developed by private sector and
23 public-private groups;

"(ii) recommendations for accelerating the development of common health care terminology standards;

"(iii) recommendations for completing development of health care information system messaging standards; and

"(iv) progress toward meeting the deadline described in paragraph (1)(B) for adoption of methods described in such paragraph.

"(B) SUBSEQUENT REPORTS.—During each of the 2 years after the year in which the report is submitted under subparagraph (A), the MITAB shall submit to Congress and the Secretary an annual report relating to additional recommendations, best practices, results of information technology improvements, analyses of private sector efforts to implement the interoperability standards established in section 1184 of the Social Security Act, and such other matters as may help ensure the most rapid dissemination of best practices in health care information technology.

"(d) STAFF AND SUPPORT SERVICES.—

"(1) EXECUTIVE DIRECTOR.—

"(A) APPOINTMENT.—The Chairperson shall appoint an executive director of the MITAB.

"(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

"(2) STAFF.—With the approval of the MITAB, the executive director may appoint such personnel as the executive director considers appropriate.

"(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the MITAB shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

"(4) EXPERTS AND CONSULTANTS.—With the approval of the MITAB, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

"(e) POWERS.—

"(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the MITAB

may hold such hearings and undertake such other activities as the MITAB determines to be necessary to carry out its duties.

"(2) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the MITAB, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the MITAB to assist the MITAB in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

"(3) TECHNICAL ASSISTANCE.—Upon the request of the MITAB, the head of a Federal agency shall provide such technical assistance to the MITAB as the MITAB determines to be necessary to carry out its duties.

"(4) OBTAINING INFORMATION.—The MITAB may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the MITAB, the head of such agency shall furnish such information to the MITAB.

1 "(f) TERMINATION.—The MITAB shall terminate 30
2 days after the date of submission of its final report under
3 subsection (c)(2)(B).

4 "(g) TESTING.—The Secretary, in consultation with
5 the MITAB, shall test the efficacy, usability, and
6 scalability, of standards within a variety of clinical settings
7 that may include a rural hospital or community health
8 center, a community hospital, a children's hospital, and
9 an urban academic center.

10 "(h) APPLICABILITY OF FACA.—The provisions of
11 the Federal Advisory Committee Act (5 U.S.C. App.) shall
12 apply to the MITAB.

13 "(i) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to the Secretary of
15 Health and Human Services such sums as are necessary
16 to carry out this section.

17 **"SEC. 934. GRANTS FOR COMPUTERIZED PHYSICIAN ORDER**
18 **ENTRY SYSTEMS.**

19 "(a) IN GENERAL.—The Secretary may award grants
20 to eligible entities to enable such entities to develop, in-
21 stall, or train personnel in the use of, computerized physi-
22 cian order entry systems.

23 "(b) ELIGIBILITY.—To be eligible to receive a grant
24 under subsection (a), an entity shall—

1 "(1) be a nonprofit hospital, health care clinic,
2 community health center, skilled nursing facility, or
3 other nonprofit entity determined to be eligible by
4 the Secretary;
5 "(2) prepare and submit to the Secretary an
6 application at such time, in such manner, and con-
7 taining such information as the Secretary may re-
8 quire, including a description of the computerized
9 medication prescribing system that the entity in-
10 tends to implement using amounts received under
11 the grant; and
12 "(3) provide assurances that are satisfactory to
13 the Secretary that any computerized physician order
14 entry systems, for which amounts are to be ex-
15 pended under an award made under subsection (a),
16 conform to the technical standards established by
17 the Secretary for such systems under section
18 932(a)(2).
19 "(c) MATCHING REQUIREMENT.—
20 "(1) IN GENERAL.—The Secretary may not
21 make a grant to an entity under subsection (a) un-
22 less that entity agrees that, with respect to the costs
23 to be incurred by the entity in carrying out the ac-
24 tivities for which the grant is being awarded, the en-
25 tity will make available (directly or through dona-

1 tions from public or private entities) non-Federal
2 contributions toward such costs in an amount equal
3 to $1 for each $2 of Federal funds provided under
4 the grant.

5 "(2) DETERMINATION OF AMOUNT CONTRIB-
6 UTED.—Non-Federal contributions required in para-
7 graph (1) may be in cash or in kind, fairly evalu-
8 ated, including equipment or services. Amounts pro-
9 vided by the Federal Government, or services as-
10 sisted or subsidized to any significant extent by the
11 Federal Government, may not be included in deter-
12 mining the amount of such non-Federal contribu-
13 tions.

14 "(d) STUDY.—

15 "(1) IN GENERAL.—The Secretary, acting
16 through The Director of the Agency for Healthcare
17 Research and Quality, shall support a study to as-
18 sess existing scientific evidence regarding the effec-
19 tiveness and cost-effectiveness of the use of elec-
20 tronic prescription programs intended to improve the
21 efficiency of prescription ordering and the safe and
22 effective use of prescription drugs. The study shall
23 address the following:

1 "(A) The ability of such programs to re-
2 duce medical errors and improve the quality
3 and safety of patient care.
4 "(B) The impact of the use of such pro-
5 grams on physicians, pharmacists, and patients,
6 including such factors as direct and indirect
7 costs, changes in productivity, and satisfaction.
8 "(C) The effectiveness of strategies for
9 overcoming barriers to the use of electronic pre-
10 scription programs.
11 "(2) REPORT.—The Secretary shall ensure
12 that, not later than 18 months after the date of en-
13 actment of this part, a report containing the find-
14 ings of the study under paragraph (1) is submitted
15 to the appropriate committees of the Congress.
16 "(3) DISSEMINATION OF FINDINGS.—The Sec-
17 retary shall disseminate the findings of the study
18 under paragraph (1) to appropriate public and pri-
19 vate entities.
20 "(e) DEFINITIONS.—In this section and section 932:
21 "(1) COMPUTERIZED PHYSICIAN ORDER ENTRY
22 SYSTEM.—The term 'computerized physician order
23 entry system' means an information technology sys-
24 tem that—
25 "(A) shall—

1 "(i) permit a qualified practitioner
2 who wishes to enter a medication order for
3 a patient to enter such order via a com-
4 puter that is linked to a database capable
5 of accessing the medical record of the pa-
6 tient who is intended to receive such medi-
7 cation;
8 "(ii) incorporate prescribing error pre-
9 vention software so that a warning (includ-
10 ing documentation regarding the cause of
11 such warning) is generated by such system
12 if a medication order is entered that is
13 likely to lead to an adverse drug event; and
14 "(iii) require documented acknowledg-
15 ment that a qualified practitioner entering
16 a medication order that has generated the
17 warning described in clause (ii) has read
18 the appropriate documentation regarding
19 the cause of such warning prior to over-
20 riding such warning; and
21 "(B) may allow for the electronic submis-
22 sion of prescriptions to pharmacies or pharmacy
23 benefit managers and the processing of such
24 submissions by pharmacies.

1 "(2) QUALIFIED PRACTITIONER.—The term
2 'qualified practitioner' means a practitioner licensed
3 to administer prescription drugs.
4 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section,
6 $100,000,000 for fiscal year 2004, and such sums as may
7 be necessary for each of fiscal years 2005 through 2008.
8 **"SEC. 935. GRANTS FOR INFORMATICS SYSTEMS.**
9 "(a) IN GENERAL.—The Secretary may establish a
10 program to make grants to eligible entities for the purpose
11 of assisting such entities in offsetting the costs related to
12 purchasing, leasing, licensing, developing, and imple-
13 menting standardized clinical health care informatics sys-
14 tems, other than computerized prescriber order entry sys-
15 tems, that are designed to improve patient safety and re-
16 duce adverse events and health care complications result-
17 ing from medication errors.
18 "(b) COSTS DEFINED.—In this section, the term
19 'costs' includes total expenditures incurred for—
20 "(1) purchasing, leasing, licensing, and install-
21 ing computer software and hardware;
22 "(2) making improvements to existing computer
23 software and hardware;

"(3) purchasing or leasing communications capabilities necessary for clinical data access, storage, and exchange; and

"(4) providing education and training to eligible entity staff on computer patient safety information systems.

"(c) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

"(1) be a hospital, health care clinic, community health center, skilled nursing facility, patient safety organization, or other entity determined to be eligible by the Secretary; and

"(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the type of informatics system that the entity intends to implement using amounts received under the grant.

"(d) TYPES OF IMFORMATICS SYSTEMS.—

"(1) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the Secretary shall identify the informatics systems, other than computerized physician order entry systems, and other information technology or telecommunications systems demonstrated to improve patient

1 safety and reduce adverse events and health care
2 complications resulting from medication errors, that
3 may be adopted and applied by eligible entities
4 through funds under this section.

5 "(2) SYSTEMS.—The systems described in para-
6 graph (1) may include bar coding, software to collect
7 and analyze medication errors, clinical decision-sup-
8 port systems, software to detect inappropriately pre-
9 scribed drugs or doses, drug utilization review pro-
10 grams, and disease management systems.

11 "(e) MATCHING REQUIREMENT.—

12 "(1) IN GENERAL.—The Secretary may not
13 make a grant to an entity under subsection (a) un-
14 less that entity agrees that, with respect to the costs
15 to be incurred by the entity in carrying out the ac-
16 tivities for which the grant is being awarded, the en-
17 tity will make available (directly or through dona-
18 tions from public or private entities) non-Federal
19 contributions toward such costs in an amount equal
20 to $1 for each $1 of Federal funds provided under
21 the grant.

22 "(2) DETERMINATION OF AMOUNT CONTRIB-
23 UTED.—Non-Federal contributions required in para-
24 graph (1) may be in cash or in kind, fairly evalu-
25 ated, including equipment or services. Amounts pro-

1 vided by the Federal Government, or services as-
2 sisted or subsidized to any significant extent by the
3 Federal Government, may not be included in deter-
4 mining the amount of such non-Federal contribu-
5 tions.

6 "(f) ADDITIONAL INFORMATION.—An eligible entity
7 receiving a grant under this section shall furnish the Sec-
8 retary with such information as the Secretary may require
9 to—

10 "(1) evaluate the project for which the grant is
11 made, including how the project has improved pa-
12 tient safety and has reduced patient safety events
13 and health care complications resulting from medica-
14 tion errors; and

15 "(2) ensure that funding provided under the
16 grant is expended for the purposes for which it is
17 made.

18 "(g) REPORTS.—

19 "(1) INTERIM REPORTS.—

20 "(A) IN GENERAL.—The Secretary shall
21 submit, at least annually, a report to the Com-
22 mittee on Health, Education, Labor, and Pen-
23 sions of the Senate and the Committee on En-
24 ergy and Commerce of the House of Represent-

atives on the grant program established under this section.

"(B) CONTENTS.—A report submitted pursuant to subparagraph (A) shall include information on—

"(i) the number of grants made;

"(ii) the nature of the projects for which funding is provided under the grant program;

"(iii) the geographic distribution of grant recipients; and

"(iv) such other matters as the Secretary determines appropriate.

"(2) FINAL REPORT.—Not later than 5 years after the date of enactment of this part, the Secretary shall submit a final report to the committees referred to in paragraph (1)(A) on the grant program.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each subsequent fiscal year.

"SEC. 936. GRANTS FOR PATIENT SAFETY RESEARCH.

"(a) IN GENERAL.—The Secretary may conduct research and award grants to promote research on patient safety.

"(b) PROCESS.—The Secretary shall establish a formal process to gather information on priorities, methodologies and approaches for medical errors, including medication errors, and patient safety research. In gathering such information, the Secretary shall ensure that input is obtained from a wide range of individuals and organizations who will use and can benefit from the availability of such information.

"(c) COORDINATION.—The Secretary shall ensure that activities are carried out under subsection (a) in cooperation and coordination with existing research initiatives, programs, and activities.

"(d) OTHER INDUSTRIES.—In carrying out this section, the Secretary shall consider the experiences of other industries in reducing errors within such industries and the processes that such industries employ to reduce errors.

"(e) ISSUES.—The issues to be addressed with respect to the research to be conducted and supported under this subsection may include—

"(1) the types and causes of errors in the provision of health care, both in the United States and internationally, such as those identified by the re-

1 porting system developed by the Linnaeus Collabora-
2 tion and the United States Pharmacopeia;
3 ''(2) the identification and comparison of trends
4 in errors in geographically and demographically di-
5 verse health care facilities;
6 ''(3) training requirements for health care pro-
7 fessionals to ensure that such professionals provide
8 quality health care generally, in specific settings,
9 and for specific practices;
10 ''(4) the development of effective communica-
11 tion methods and tools between disciplines to im-
12 prove patient safety;
13 ''(5) the use of interdisciplinary teams to im-
14 prove patient safety;
15 ''(6) the barriers to medical error reduction
16 strategies;
17 ''(7) the use of standardized processes in pro-
18 viding medication, including the application of these
19 processes in demographically diverse health care fa-
20 cilities;
21 ''(8) the application of a national standardized
22 taxonomy for medication errors;
23 ''(9) the effect of educational programs on the
24 consistent application of standardized definitions,
25 terminology, and formats; and

"(10) other areas determined appropriate by the Secretary.

"(f) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

"(1) be a patient safety organization, health care provider, health care provider association, research organization, university, or other entity determined to be eligible by the Secretary; and

"(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each subsequent fiscal year.".

SEC. 304. REQUIRED USE OF PRODUCT IDENTIFICATION TECHNOLOGY.

The Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) is amended—

(1) in section 502, by adding at the end the following:

"(u) If it is a drug or biological product, unless it includes a unique product identifier for the drug or bio-

1 logical product as required by regulations under section
2 510(o).''; and
3 (2) in section 510, by adding at the end the fol-
4 lowing:
5 ''(o)(1) The Secretary shall issue, and may periodi-
6 cally revise, regulations requiring the manufacturer of any
7 drug or biological product, or the packager or labeler of
8 a drug or biological product, to include a unique product
9 identifier on the packaging of the drug or biological prod-
10 uct.
11 ''(2) For purposes of this subsection, the term
12 'unique product identifier' means an identification that—
13 ''(A) is affixed by the manufacturer, labeler, or
14 packager to each drug or biological product de-
15 scribed in paragraph (1);
16 ''(B) uniquely identifies the item and meets the
17 standards required by this section; and
18 ''(C) can be read by a scanning device or other
19 technology acceptable to the Secretary.
20 ''(3) A unique product identifier required by regula-
21 tions issued or revised under paragraph (1) shall be based
22 on—
23 ''(A) the National Drug Code maintained by
24 the Food and Drug Administration;

"(B) commercially accepted standards established by organizations that are accredited by the American National Standards Institute, such as the Health Industry Business Communication Council or the Uniform Code Council; or

"(C) other identification formats that the Secretary deems appropriate.

"(4) The Secretary may, at the Secretary's discretion, waive the requirements of this subsection, or add additional provisions that are necessary to safeguard the public health.".

TITLE IV—TAX CREDIT FOR OFFERING EMPLOYER-BASED HEALTH INSURANCE COVERAGE

SEC. 401. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following:

"SEC. 45G. EMPLOYEE HEALTH INSURANCE EXPENSES.

"(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the employee health insurance expenses credit determined under this

1 section is an amount equal to the applicable percentage
2 of the amount paid by the taxpayer during the taxable
3 year for qualified employee health insurance expenses.

4 "(b) APPLICABLE PERCENTAGE.—For purposes of
5 subsection (a)—

6 "(1) IN GENERAL.—Except as provided in para-
7 graphs (2) and (3), the applicable percentage is
8 equal to 50 percent reduced (but not below zero) by
9 1.25 percentage points for each qualified employee
10 of the employer in excess of 10 qualified employees
11 (as determined under the rules under subsection
12 (c)(1)).

13 "(2) LIMITATION BASED ON ANNUAL WAGES.—

14 "(A) IN GENERAL.—The percentage which
15 would (but for this paragraph) be taken into ac-
16 count as the applicable percentage for purposes
17 of subsection (a) for the taxable year shall be
18 reduced (but not below zero) by the applicable
19 percentage points for each $1,000 (or fraction
20 thereof) by which the average amount of wages
21 paid or incurred by an eligible small employer
22 to qualified employees at an annual rate during
23 the taxable year exceeds $10,000.

"(B) APPLICABLE PERCENTAGE POINTS.—For purposes of subparagraph (A), the applicable percentage points are equal to—

"(i) in the case of an employer with not more than 10 qualified employees (as so determined), 2.22 percentage points, and

"(ii) in the case of an employer with more than 10 qualified employees (as so determined), the ratio of the number of qualified employees of such employer to 450, expressed as percentage points.

"(C) WAGES.—For purposes of this paragraph, the term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

"(3) HIGH CONTRIBUTION BONUS.—With respect to any taxable year during which an eligible small employer pays 100 percent of qualified employee health insurance expenses for the qualified employees of the small employer, the applicable percentage otherwise determined for such taxable year under the preceding paragraphs of this subsection shall be increased by 5 percentage points.

1 "(c) DEFINITIONS.—For purposes of this section—
2 "(1) ELIGIBLE SMALL EMPLOYER.—
3 "(A) IN GENERAL.—The term 'eligible
4 small employer' means, with respect to any tax-
5 able year, any employer if such employer em-
6 ployed an average of 50 or fewer employees on
7 business days during either of the 2 preceding
8 taxable years. For purposes of the preceding
9 sentence, a preceding taxable year may be
10 taken into account only if the employer was in
11 existence throughout such year.
12 "(B) EMPLOYERS NOT IN EXISTENCE IN
13 PRECEDING YEAR.—In the case of an employer
14 which was not in existence throughout the 1st
15 preceding taxable year, the determination under
16 subparagraph (A) shall be based on the average
17 number of employees that it is reasonably ex-
18 pected such employer will employ on business
19 days in the current taxable year.
20 "(2) QUALIFIED EMPLOYEE HEALTH INSUR-
21 ANCE EXPENSES.—
22 "(A) IN GENERAL.—The term 'qualified
23 employee health insurance expenses' means any
24 amount paid by an employer for health insur-
25 ance coverage to the extent such amount is at-

tributable to coverage provided to any employee while such employee is a qualified employee.

"(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account under subparagraph (A).

"(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1).

"(3) QUALIFIED EMPLOYEE.—

"(A) IN GENERAL.—The term 'qualified employee' means, with respect to any period, an employee of an employer who is not provided health insurance coverage under—

"(i) a health plan of the employee's spouse,

"(ii) title XVIII, XIX, or XXI of the Social Security Act,

"(iii) chapter 17 of title 38, United States Code,

"(iv) chapter 55 of title 10, United States Code,

"(v) chapter 89 of title 5, United States Code,

"(vi) the Indian Health Care Improvement Act, or

"(vii) any other provision of law.

"(B) TREATMENT OF CERTAIN EMPLOYEES.—For purposes of subparagraph (A), the term 'employee'—

"(i) shall not include an employee within the meaning of section 401(c)(1), and

"(ii) shall include a leased employee within the meaning of section 414(n).

"(d) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

"(e) DENIAL OF DOUBLE BENEFIT.—No deduction or credit under any other provision of this chapter shall be allowed with respect to qualified employee health insurance expenses taken into account under subsection (a).".

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking "plus" at the end of paragraph (14), by strik-

ing the period at the end of paragraph (15) and inserting ", plus", and by adding at the end the following:

"(16) the employee health insurance expenses credit determined under section 45G.".

(c) NO CARRYBACKS.—Subsection (d) of section 39 of the Internal Revenue Code of 1986 (relating to carryback and carryforward of unused credits) is amended by adding at the end the following:

"(11) NO CARRYBACK OF SECTION 45G CREDIT BEFORE EFFECTIVE DATE.—No portion of the unused business credit for any taxable year which is attributable to the employee health insurance expenses credit determined under section 45G may be carried back to a taxable year ending before the date of the enactment of section 45G.".

(d) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 45G. Employee health insurance expenses.".

(e) EMPLOYER OUTREACH.—The Internal Revenue Service shall, in conjunction with the Small Business Administration, develop materials and implement an educational program to ensure that business personnel are aware of—

(1) the eligibility criteria for the tax credit provided under section 45G of the Internal Revenue Code of 1986 (as added by this section),

(2) the methods to be used in calculating such credit, and

(3) the documentation needed in order to claim such credit,

so that the maximum number of eligible businesses may claim the tax credit.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after the date of the enactment of this Act.

TITLE V—FAMILYCARE

SEC. 501. RENAMING OF TITLE XXI PROGRAM.

(a) IN GENERAL.—The heading of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended to read as follows:

''TITLE XXI—FAMILYCARE PROGRAM''.

(b) PROGRAM REFERENCES.—Any reference in any provision of Federal law or regulation to ''SCHIP'' or ''State children's health insurance program'' under title XXI of the Social Security Act shall be deemed a reference to the FamilyCare program under such title.

SEC. 502. FAMILYCARE COVERAGE OF PARENTS AND PREGNANT WOMEN UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) INCENTIVES TO IMPLEMENT FAMILYCARE COVERAGE.—

(1) UNDER MEDICAID.—

(A) ESTABLISHMENT OF NEW OPTIONAL ELIGIBILITY CATEGORY.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(i) by striking ''or'' at the end of subclause (XVII);

(ii) by adding ''or'' at the end of subclause (XVIII); and

(iii) by adding at the end the following:

''(XIX) who are individuals described in subsection (k)(1) (relating to parents of categorically eligible children);''.

(B) PARENTS DESCRIBED.—Section 1902 of the Social Security Act is further amended by inserting after subsection (j) the following:

''(k)(1)(A) Individuals described in this paragraph are individuals—

1 "(i) who are the parents of an individual who
2 is under 19 years of age (or such higher age as the
3 State may have elected under section 1902(l)(1)(D)
4 (as amended by section 505 of the Health Care Cov-
5 erage Expansion and Quality Improvement Act of
6 2003) and who is eligible for medical assistance
7 under subsection (a)(10)(A);
8 "(ii) who are not otherwise eligible for medical
9 assistance under such subsection or under a waiver
10 approved under section 1115 or otherwise (except
11 under section 1931 or under subsection
12 (a)(10)(A)(ii)(XIX)); and
13 "(iii) whose family income exceeds the effective
14 income level or resource level applicable under the
15 State plan under part A of title IV as in effect as
16 of July 16, 1996, but does not exceed the highest ef-
17 fective income level applicable to a child in the fam-
18 ily under this title.
19 "(B) In establishing an income eligibility level for in-
20 dividuals described in this paragraph, a State may vary
21 such level consistent with the various income levels estab-
22 lished under subsection (l)(2) based on the ages of chil-
23 dren described in subsection (l)(1) in order to ensure, to
24 the maximum extent possible, that such individuals shall
25 be enrolled in the same program as their children.

"(C) An individual may not be treated as being described in this paragraph unless, at the time of the individual's enrollment under this title, the child referred to in subparagraph (A)(i) of the individual is also enrolled under this title.

"(D) In this subsection, the term 'parent' has the meaning given the term 'caretaker relative' for purposes of carrying out section 1931.

"(2) In the case of a parent described in paragraph (1) who is also the parent of a child who is eligible for child health assistance under title XXI, the State may elect (on a uniform basis) to cover all such parents under section 2111 or under this title.".

(C) ENHANCED MATCHING FUNDS AVAILABLE IF CERTAIN CONDITIONS MET.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in the fourth sentence of subsection (b), by striking "or subsection (u)(3)" and inserting ", (u)(3), or (u)(4)"; and

(ii) in subsection (u)—

(I) by redesignating paragraph (4) as paragraph (6), and

(II) by inserting after paragraph (3) the following:

"(4) For purposes of subsection (b) and section 2105(a)(1):

"(A) FAMILYCARE PARENTS.—The expenditures described in this subparagraph are the expenditures described in the following clauses (i) and (ii):

"(i) PARENTS.—If the conditions described in clause (iii) are met, expenditures for medical assistance for parents described in section 1902(k)(1) and for parents who would be described in such section but for the fact that they are eligible for medical assistance under section 1931 or under a waiver approved under section 1115.

"(ii) CERTAIN PREGNANT WOMEN.—If the conditions described in clause (iv) are met, expenditures for medical assistance for pregnant women described in subsection (n) or under section 1902(l)(1)(A) in a family the income of which exceeds the effective income level applicable under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 to a family of the size involved as of January 1, 2003.

1 "(iii) CONDITIONS FOR EXPENDITURES
2 FOR PARENTS.—The conditions described in
3 this clause are the following:
4 "(I) The State has a State child
5 health plan under title XXI which (wheth-
6 er implemented under such title or under
7 this title) has an effective income level for
8 children that is at least 200 percent of the
9 poverty line.
10 "(II) Such State child health plan
11 does not limit the acceptance of applica-
12 tions, does not use a waiting list for chil-
13 dren who meet eligibility standards to
14 qualify for assistance, and provides bene-
15 fits to all children in the State who apply
16 for and meet eligibility standards.
17 "(III) The State plans under this title
18 and title XXI do not provide coverage for
19 parents with higher family income without
20 covering parents with a lower family in-
21 come.
22 "(IV) The State does not apply an in-
23 come level for parents that is lower than
24 the effective income level (expressed as a
25 percent of the poverty line) that has been

specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of January 1, 2003, to be eligible for medical assistance as a parent under this title.

"(iv) CONDITIONS FOR EXPENDITURES FOR CERTAIN PREGNANT WOMEN.—The conditions described in this clause are the following:

"(I) The State has established an effective income eligibility level for pregnant women under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 that is at least 185 percent of the poverty line.

"(II) The State plans under this title and title XXI do not provide coverage for pregnant women described in subparagraph (A)(ii) with higher family income without covering such pregnant women with a lower family income.

"(III) The State does not apply an income level for pregnant women that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income dis-

regards) that has been specified under the State plan under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2003, to be eligible for medical assistance as a pregnant woman.

''(IV) The State satisfies the conditions described in subclauses (I) and (II) of clause (iii).

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

''(I) The term 'parent' has the meaning given such term for purposes of section 1902(k)(1).

''(II) The term 'poverty line' has the meaning given such term in section 2110(c)(5).''.

(D) APPROPRIATION FROM TITLE XXI ALLOTMENT FOR MEDICAID EXPANSION COSTS FOR PARENTS; ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.—Subparagraph (B) of section 2105(a)(1) of the Social Security Act, as amended by section 515(a), is amended to read as follows:

"(B) FAMILYCARE PARENTS.—Expenditures for medical assistance that are attributable to expenditures described in section 1905(u)(4)(A).".

(E) ONLY COUNTING ENHANCED PORTION FOR COVERAGE OF ADDITIONAL PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in the fourth sentence of subsection (b), by inserting "(except in the case of expenditures described in subsection (u)(5))" after "do not exceed";

(ii) in subsection (u), by inserting after paragraph (4) (as inserted by subparagraph (C)), the following:

"(5) For purposes of the fourth sentence of subsection (b) and section 2105(a), the following payments under this title do not count against a State's allotment under section 2104:

"(A) REGULAR FMAP FOR EXPENDITURES FOR PREGNANT WOMEN WITH INCOME ABOVE JANUARY 1, 2003 INCOME LEVEL AND BELOW 185 PERCENT OF POVERTY.—The portion of the payments made for expenditures described in paragraph (4)(A)(ii) that represents the amount that would have been paid if

the enhanced FMAP had not been substituted for the Federal medical assistance percentage.''.

(2) UNDER TITLE XXI.—

(A) FAMILYCARE COVERAGE.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. OPTIONAL FAMILYCARE COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN OR TARGETED LOW-INCOME PREGNANT WOMEN.

''(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of parent health assistance for targeted low-income parents, pregnancy-related assistance for targeted low-income pregnant women, or both, in accordance with this section, but only if—

''(1) with respect to the provision of parent health assistance, the State meets the conditions described in clause (iii) of section 1905(u)(4)(A);

''(2) with respect to the provision of pregnancy-related assistance, the State meets the conditions described in clause (iv) of section 1905(u)(4)(A); and

"(3) in the case of parent health assistance for targeted low-income parents, the State elects to provide medical assistance under section 1902(a)(10)(A)(ii)(XIX), under section 1931, or under a waiver under section 1115 to individuals described in section 1902(k)(1)(A)(i) and elects an effective income level that, consistent with paragraphs (1)(B) and (2) of section 1902(k), ensures to the maximum extent possible, that such individuals shall be enrolled in the same program as their children if their children are eligible for coverage under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)).".

"(b) DEFINITIONS.—For purposes of this title:

"(1) PARENT HEALTH ASSISTANCE.—The term 'parent health assistance' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income parents.

"(2) PARENT.—The term 'parent' has the meaning given the term 'caretaker relative' for purposes of carrying out section 1931.

"(3) PREGNANCY-RELATED ASSISTANCE.—The term 'pregnancy-related assistance' has the meaning given the term child health assistance in section

2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women, except that the assistance shall be limited to services related to pregnancy (which include prenatal, delivery, and postpartum services) and to other conditions that may complicate pregnancy.

"(4) TARGETED LOW-INCOME PARENT.—The term 'targeted low-income parent' has the meaning given the term targeted low-income child in section 2110(b) as if the reference to a child were deemed a reference to a parent (as defined in paragraph (3)) of the child; except that in applying such section—

"(A) there shall be substituted for the income level described in paragraph (1)(B)(ii)(I) the applicable income level in effect for a targeted low-income child;

"(B) in paragraph (3), January 1, 2003, shall be substituted for July 1, 1997; and

"(C) in paragraph (4), January 1, 2003, shall be substituted for March 31, 1997.

"(5) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' has the meaning given the term targeted low-income child in section 2110(b) as if any ref-

erence to a child were a reference to a woman during pregnancy and through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends; except that in applying such section—

"(A) there shall be substituted for the income level described in paragraph (1)(B)(ii)(I) the applicable income level in effect for a targeted low-income child;

"(B) in paragraph (3), January 1, 2003, shall be substituted for July 1, 1997; and

"(C) in paragraph (4), January 1, 2003, shall be substituted for March 31, 1997.

"(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of parent health assistance to targeted low-income parents or pregnancy-related assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

"(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income parent or a targeted low-income pregnant woman (as applicable).

"(2) Any such reference to child health assistance—

"(A) with respect to such parents is deemed a reference to parent health assistance; and

"(B) with respect to such pregnant women, is deemed a reference to pregnancy-related assistance.

"(3) In applying section 2103(e)(3)(B) in the case of a family or pregnant woman provided coverage under this section, the limitation on total annual aggregate cost-sharing shall be applied to the entire family or such pregnant woman.

"(4) In applying section 2110(b)(4), any reference to 'section 1902(l)(2) or 1905(n)(2) (as selected by a State)' is deemed a reference to the effective income level applicable to parents under section 1931 or under a waiver approved under section 1115, or, in the case of a pregnant woman, the income level established under section 1902(l)(2)(A).

"(5) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to parents and pregnant women.".

(B) ADDITIONAL ALLOTMENT FOR STATES PROVIDING COVERAGE OF PARENTS OR PREGNANT WOMEN.—

(i) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by inserting after subsection (c) the following:

"(d) ADDITIONAL ALLOTMENTS FOR STATE COVERAGE OF PARENTS OR PREGNANT WOMEN.—

"(1) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing additional allotments to States under this title, there is appropriated, out of any money in the Treasury not otherwise appropriated—

"(A) for fiscal year 2004, $2,000,000,000;

"(B) for fiscal year 2005, $4,000,000,000;

"(C) for fiscal year 2006, $4,000,000,000;

"(D) for fiscal year 2007, $5,000,000,000;

"(E) for fiscal year 2008, $5,000,000,000;

"(F) for fiscal year 2009, $6,000,000,000;

"(G) for fiscal year 2010, $7,000,000,000;

"(H) for fiscal year 2011, $8,000,000,000;

"(I) for fiscal year 2012, $9,000,000,000;

"(J) for fiscal year 2013 and each fiscal year thereafter, the amount of the allotment

provided under this paragraph for the preceding fiscal year increased by the percentage increase (if any) in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average).

"(2) STATE AND TERRITORIAL ALLOTMENTS.—

"(A) IN GENERAL.—In addition to the allotments provided under subsections (b) and (c), subject to paragraphs (3) and (4), of the amount available for the additional allotments under paragraph (1) for a fiscal year, the Secretary shall allot to each State with a State child health plan approved under this title—

"(i) in the case of such a State other than a commonwealth or territory described in subparagraph (B), the same proportion as the proportion of the State's allotment under subsection (b) (determined without regard to subsection (f)) to the total amount of the allotments under subsection (b) for such States eligible for an allotment under this paragraph for such fiscal year; and

"(ii) in the case of a commonwealth or territory described in subsection (c)(3), the

same proportion as the proportion of the commonwealth's or territory's allotment under subsection (c) (determined without regard to subsection (f)) to the total amount of the allotments under subsection (c) for commonwealths and territories eligible for an allotment under this paragraph for such fiscal year.

"(B) AVAILABILITY AND REDISTRIBUTION OF UNUSED ALLOTMENTS.—In applying subsections (e) and (f) with respect to additional allotments made available under this subsection, the procedures established under such subsections shall ensure such additional allotments are only made available to States which have elected to provide coverage under section 2111.

"(3) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are not available for amounts expended before October 1, 2003. Such amounts are available for amounts expended on or after such date for child health assistance for targeted low-income children, as well as for parent health assistance for targeted low-income parents, and pregnancy-related assistance for targeted low-income pregnant women.

"(4) REQUIRING ELECTION TO PROVIDE COVERAGE.—No payments may be made to a State under this title from an allotment provided under this subsection unless the State has made an election to provide parent health assistance for targeted low-income parents, or pregnancy-related assistance for targeted low-income pregnant women.".

(ii) CONFORMING AMENDMENTS.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(I) in subsection (a), by inserting "subject to subsection (d)," after "under this section,";

(II) in subsection (b)(1), by inserting "and subsection (d)" after "Subject to paragraph (4)"; and

(III) in subsection (c)(1), by inserting "subject to subsection (d)," after "for a fiscal year,".

(C) NO COST-SHARING FOR PREGNANCY-RELATED BENEFITS.—Section 2103(e)(2) of the Social Security Act (42 U.S.C. 1397cc(e)(2)) is amended—

(i) in the heading, by inserting ''AND PREGNANCY-RELATED SERVICES'' after ''PREVENTIVE SERVICES''; and

(ii) by inserting before the period at the end the following: ''and for pregnancy-related services''.

(3) EFFECTIVE DATE.—The amendments made by this subsection apply to items and services furnished on or after October 1, 2003, without regard to whether regulations implementing such amendments have been issued.

(b) OPTIONAL APPLICATION OF PRESUMPTIVE ELIGIBILITY PROVISIONS TO PARENTS.—Section 1920A of the Social Security Act (42 U.S.C. 1396r–1a) is amended by adding at the end the following:

''(e) A State may elect to apply the previous provisions of this section to provide for a period of presumptive eligibility for medical assistance for a parent (as defined for purposes of section 1902(k)(1)) of a child with respect to whom such a period is provided under this section.''.

(c) CONFORMING AMENDMENTS.—

(1) ELIGIBILITY CATEGORIES.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the matter before paragraph (1)—

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

(B) by inserting ''or'' at the end of clause (xiii); and

(C) by inserting after clause (xiii) the following:

''(xiv) who are parents described (or treated as if described) in section 1902(k)(1),''.

(2) INCOME LIMITATIONS.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(ii)(XIX),'' after ''1902(a)(10)(A)(ii)(XVIII),''.

(3) CONFORMING AMENDMENT RELATING TO NO WAITING PERIOD FOR PREGNANT WOMEN.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) by striking '', and'' at the end of clause (i) and inserting a semicolon;

(B) by striking the period at the end of clause (ii) and inserting ''; and''; and

(C) by adding at the end the following:

''(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income parent who is pregnant.''.

SEC. 503. AUTOMATIC ENROLLMENT OF CHILDREN BORN TO TITLE XXI PARENTS.

(a) TITLE XXI.—Section 2102(b)(1) (42 U.S.C. 1397bb(b)(1)) is amended by adding at the end the following:

"(C) AUTOMATIC ELIGIBILITY OF CHILDREN BORN TO PARENTS OR PREGNANT WOMEN.—Such eligibility standards shall provide for automatic coverage of a child born to an individual who is provided assistance under this title in the same manner as medical assistance would be provided under section 1902(e)(4) to a child described in such section.".

(b) CONFORMING AMENDMENT TO MEDICAID.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking "so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance".

SEC. 504. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) MEDICAID PROGRAM.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended—

1 (1) in paragraph (1), by striking ''paragraph
2 (2)'' and inserting ''paragraphs (2) and (4)''; and
3 (2) by adding at the end the following:
4 ''(4)(A) A State may elect (in a plan amendment
5 under this title) to provide medical assistance under this
6 title for aliens who are lawfully residing in the United
7 States (including battered aliens described in section
8 431(c) of the Personal Responsibility and Work Oppor-
9 tunity Reconciliation Act of 1996) and who are otherwise
10 eligible for such assistance, within any of the following eli-
11 gibility categories:
12 ''(i) PREGNANT WOMEN.—Women during preg-
13 nancy (and during the 60-day period beginning on
14 the last day of the pregnancy).
15 ''(ii) CHILDREN.—Children (as defined under
16 such plan), including optional targeted low-income
17 children described in section 1905(u)(2)(B).
18 ''(iii) PARENTS.—If the State has elected the
19 eligibility category described in clause (ii), caretaker
20 relatives who are parents (including individuals
21 treated as a caregiver for purposes of carrying out
22 section 1931) of children (described in such clause
23 or otherwise) who are eligible for medical assistance
24 under the plan.

"(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

"(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).".

(b) TITLE XXI.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following:

"(E) Section 1903(v)(4) (relating to optional coverage of categories of lawful resident alien pregnant women, children, and parents), but only with respect to an eligibility category under this title, if the same eligibility category has been elected under such section for purposes of title XIX.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003, and apply to medical assistance and child health assistance furnished

on or after such date, whether or not regulations implementing such amendments have been issued.

SEC. 505. OPTIONAL COVERAGE OF CHILDREN THROUGH AGE 20 UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1902(l)(1)(D) of the Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting ''(or, at the election of a State, 20 or 21 years of age)'' after ''19 years of age''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(e)(3)(A) of the Social Security Act (42 U.S.C. 1396a(e)(3)(A)) is amended by inserting ''(or 1 year less than the age the State has elected under subsection (l)(1)(D))'' after ''18 years of age''.

(B) Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended by inserting ''or such higher age as the State has elected under subsection (l)(1)(D)'' after ''19 years of age''.

(C) Section 1920A(b)(1) of the Social Security Act (42 U.S.C. 1396r–1a(b)(1)) is amended by inserting ''or such higher age as

the State has elected under section 1902(l)(1)(D)'' after ''19 years of age''.

(D) Section 1928(h)(1) of the Social Security Act (42 U.S.C. 1396s(h)(1)) is amended by inserting ''or 1 year less than the age the State has elected under section 1902(l)(1)(D)'' before the period at the end.

(E) Section 1932(a)(2)(A) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting ''(or such higher age as the State has elected under section 1902(l)(1)(D))'' after ''19 years of age''.

(b) TITLE XXI.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by inserting ''(or such higher age as the State has elected under section 1902(l)(1)(D))''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003, and apply to medical assistance and child health assistance provided on or after such date, whether or not regulations implementing such amendments have been issued.

SEC. 506. APPLICATION OF SIMPLIFIED TITLE XXI PROCEDURES UNDER THE MEDICAID PROGRAM.

(a) APPLICATION UNDER MEDICAID.—

1 (1) IN GENERAL.—Section 1902(l) of the Social
2 Security Act (42 U.S.C. 1396a(l)) is amended—
3 (A) in paragraph (3), by inserting ''subject
4 to paragraph (5)'', after ''Notwithstanding sub-
5 section (a)(17),''; and
6 (B) by adding at the end the following:
7 ''(5) With respect to determining the eligibility of in-
8 dividuals under 19 years of age (or such higher age as
9 the State has elected under paragraph (1)(D)) for medical
10 assistance under subsection (a)(10)(A) and, separately,
11 with respect to determining the eligibility of individuals
12 for medical assistance under subsection
13 (a)(10)(A)(i)(VIII) or (a)(10)(A)(ii)(XIX), notwith-
14 standing any other provision of this title, if the State has
15 established a State child health plan under title XXI—
16 ''(A) the State may not apply a resource stand-
17 ard;
18 ''(B) the State shall use the same simplified eli-
19 gibility form (including, if applicable, permitting ap-
20 plication other than in person) as the State uses
21 under such State child health plan with respect to
22 such individuals;
23 ''(C) the State shall provide for initial eligibility
24 determinations and redeterminations of eligibility
25 using verification policies, forms, and frequency that

are no less restrictive than the policies, forms, and frequency the State uses for such purposes under such State child health plan with respect to such individuals; and

"(D) the State shall not require a face-to-face interview for purposes of initial eligibility determinations and redeterminations unless the State requires such an interview for such purposes under such child health plan with respect to such individuals.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to determinations of eligibility made on or after the date that is 1 year after the date of the enactment of this Act, whether or not regulations implementing such amendments have been issued.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Section 1920A(b)(3)(A)(i) of the Social Security Act (42 U.S.C. 1396r–1a(b)(3)(A)(i)) is amended by inserting "a child care resource and referral agency," after "a State or tribal child support enforcement agency,".

(2) APPLICATION TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) of the Social Security Act (42 U.S.C. 1396r–1(b)) is amended by adding at the end after

and below paragraph (2) the following flush sentence:

"The term 'qualified provider' includes a qualified entity as defined in section 1920A(b)(3).".

(3) APPLICATION UNDER TITLE XXI.—

(A) IN GENERAL.—Section 2107(e)(1)(D) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

"(D) Sections 1920 and 1920A (relating to presumptive eligibility).".

(B) CONFORMING ELIMINATION OF RESOURCE TEST.—Section 2102(b)(1)(A) of such Act (42 U.S.C. 1397bb(b)(1)(A)) is amended—

(i) by striking " and resources (including any standards relating to spenddowns and disposition of resources)"; and

(ii) by adding at the end the following: "Effective 1 year after the date of the enactment of the Health Care Coverage Expansion and Quality Improvement Act of 2003, such standards may not include the application of a resource standard or test.".

(c) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR TITLE XXI AND MEDICAID BENEFITS FOR CHILDREN LOSING MEDICAID OR TITLE XXI ELIGIBILITY.—

(1) LOSS OF MEDICAID ELIGIBILITY.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking the period at the end of paragraph (65) and inserting "; and", and

(B) by inserting after paragraph (65) the following:

"(66) provide, in the case of a State with a State child health plan under title XXI, that before medical assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XXI shall be made and, if determined to be so eligible, the child (or parent) shall be automatically enrolled in the program under such title without the need for a new application.".

(2) LOSS OF TITLE XXI ELIGIBILITY AND COORDINATION WITH MEDICAID.—Section 2102(b) of the Social Security Act (42 U.S.C. 1397bb(b)) is amended—

(A) in paragraph (3), by redesignating subparagraphs (D) and (E) as subparagraphs

(E) and (F), respectively, and by inserting after subparagraph (C) the following:

"(D) that before health assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XIX is made and, if determined to be so eligible, the child (or parent) is automatically enrolled in the program under such title without the need for a new application;";

(B) by redesignating paragraph (4) as paragraph (5); and

(C) by inserting after paragraph (3) the following new paragraph:

"(4) COORDINATION WITH MEDICAID.—The State shall coordinate the screening and enrollment of individuals under this title and under title XIX consistent with the following:

"(A) Information that is collected under this title or under title XIX which is needed to make an eligibility determination under the other title shall be transmitted to the appropriate administering entity under such other title in a timely manner so that coverage is not delayed and families do not have to submit the

same information twice. Families shall be provided the information they need to complete the application process for coverage under both titles and be given appropriate notice of any determinations made on their applications for such coverage.

''(B) If a State does not use a joint application under this title and such title, the State shall—

''(i) promptly inform a child's parent or caretaker in writing and, if appropriate, orally, that a child has been found likely to be eligible under title XIX;

''(ii) provide the family with an application for medical assistance under such title and offer information about what (if any) further information, documentation, or other steps are needed to complete such application process;

''(iii) offer assistance in completing such application process; and

''(iv) promptly transmit the separate application under this title or the information obtained through such application, and all other relevant information and doc-

1 umentation, including the results of the
2 screening process, to the State agency
3 under title XIX for a final determination
4 on eligibility under such title.
5 ''(C) Applicants are notified in writing
6 of—
7 ''(i) benefits (including restrictions on
8 cost-sharing) under title XIX; and
9 ''(ii) eligibility rules that prohibit chil-
10 dren who have been screened eligible for
11 medical assistance under such title from
12 being enrolled under this title, other than
13 provisional temporary enrollment while a
14 final eligibility determination is being made
15 under such title.
16 ''(D) If the agency administering this title
17 is different from the agency administering a
18 State plan under title XIX, such agencies shall
19 coordinate the screening and enrollment of ap-
20 plicants for such coverage under both titles.
21 ''(E) The coordination procedures estab-
22 lished between the program under this title and
23 under title XIX shall apply not only to the ini-
24 tial eligibility determination of a family but also

to any renewals or redeterminations of such eligibility.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) apply to individuals who lose eligibility under the medicaid program under title XIX, or under a State child health insurance plan under title XXI, respectively, of the Social Security Act on or after October 1, 2003 (or, if later, 60 days after the date of the enactment of this Act), whether or not regulations implementing such amendments have been issued.

(d) PROVISION OF MEDICAID AND CHIP APPLICATIONS AND INFORMATION UNDER THE SCHOOL LUNCH PROGRAM.—Section 9(b)(2)(B) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(2)(B)) is amended—

(1) by striking ''(B) Applications'' and inserting ''(B)(i) Applications''; and

(2) by adding at the end the following:

''(ii)(I) Applications for free and reduced price lunches that are distributed pursuant to clause (i) to parents or guardians of children in attendance at schools participating in the school lunch program under this Act shall also contain information on the availability of medical assistance under title XIX of the Social Security Act (42

U.S.C. 1396 et seq.) and of child health and FamilyCare assistance under title XXI of such Act, including information on how to obtain an application for assistance under such programs.

"(II) Information on the programs referred to in subclause (I) shall be provided on a form separate from the application form for free and reduced price lunches under clause (i).".

(e) 12-MONTHS CONTINUOUS ELIGIBILITY.—

(1) MEDICAID.—Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended—

(A) by striking "At the option of the State, the plan may" and inserting "The plan shall";

(B) by striking "an age specified by the State (not to exceed 19 years of age)" and inserting "19 years of age (or such higher age as the State has elected under subsection (l)(1)(D)) or, at the option of the State, who is eligible for medical assistance as the parent of such a child"; and

(C) in subparagraph (A), by striking "a period (not to exceed 12 months) " and inserting "the 12-month period beginning on the date".

(2) TITLE XXI.—Section 2102(b)(2) of such Act (42 U.S.C. 1397bb(b)(2)) is amended by adding at the end the following: ''Such methods shall provide 12-months continuous eligibility for children under this title in the same manner that section 1902(e)(12) provides 12-months continuous eligibility for children described in such section under title XIX. If a State has elected to apply section 1902(e)(12) to parents, such methods may provide 12-months continuous eligibility for parents under this title in the same manner that such section provides 12-months continuous eligibility for parents described in such section under title XIX.''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by this subsection shall take effect on October 1, 2003 (or, if later, 60 days after the date of the enactment of this Act), whether or not regulations implementing such amendments have been issued.

SEC. 507. IMPROVING WELFARE-TO-WORK TRANSITION UNDER THE MEDICAID PROGRAM.

(a) OPTION OF CONTINUOUS ELIGIBILITY FOR 12 MONTHS; OPTION OF CONTINUING COVERAGE FOR UP TO AN ADDITIONAL YEAR.—

(1) OPTION OF CONTINUOUS ELIGIBILITY FOR 12 MONTHS BY MAKING REPORTING REQUIREMENTS OPTIONAL.—Section 1925(b) (42 U.S.C. 1396r–6(b)) is amended—

(A) in paragraph (1), by inserting ", at the option of a State," after "and which";

(B) in paragraph (2)(A), by inserting "Subject to subparagraph (C):" after "(A) NOTICES.—";

(C) in paragraph (2)(B), by inserting "Subject to subparagraph (C):" after "(B) REPORTING REQUIREMENTS.—";

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

"(C) STATE OPTION TO WAIVE NOTICE AND REPORTING REQUIREMENTS.—A State may waive some or all of the reporting requirements under clauses (i) and (ii) of subparagraph (B). Insofar as it waives such a reporting requirement, the State need not provide for a notice under subparagraph (A) relating to such requirement."; and

(E) in paragraph (3)(A)(iii), by inserting "the State has not waived under paragraph (2)(C) the reporting requirement with respect

to such month under paragraph (2)(B) and if'' after ''6-month period if''.

(2) STATE OPTION TO EXTEND ELIGIBILITY FOR LOW-INCOME INDIVIDUALS FOR UP TO 12 ADDITIONAL MONTHS.—Section 1925 (42 U.S.C. 1396r–6) is further amended—

(A) by redesignating subsections (c) through (f) as subsections (d) through (g), respectively; and

(B) by inserting after subsection (b) the following new subsection:

''(c) STATE OPTION OF UP TO 12 MONTHS OF ADDITIONAL ELIGIBILITY.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, each State plan approved under this title may provide, at the option of the State, that the State shall offer to each family which received assistance during the entire 6-month period under subsection (b) and which meets the applicable requirement of paragraph (2), in the last month of the period the option of extending coverage under this subsection for the succeeding period not to exceed 12 months.

''(2) INCOME RESTRICTION.—The option under paragraph (1) shall not be made available to a fam-

ily for a succeeding period unless the State determines that the family's average gross monthly earnings (less such costs for such child care as is necessary for the employment of the caretaker relative) as of the end of the 6-month period under subsection (b) does not exceed 185 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(3) APPLICATION OF EXTENSION RULES.—The provisions of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply to the extension provided under this subsection in the same manner as they apply to the extension provided under subsection (b)(1), except that for purposes of this subsection—

"(A) any reference to a 6-month period under subsection (b)(1) is deemed a reference to the extension period provided under paragraph (1) and any deadlines for any notices or reporting and the premium payment periods shall be modified to correspond to the appro-

priate calendar quarters of coverage provided under this subsection; and

"(B) any reference to a provision of subsection (a) or (b) is deemed a reference to the corresponding provision of subsection (b) or of this subsection, respectively.".

(b) STATE OPTION TO WAIVE RECEIPT OF MEDICAID FOR 3 OF PREVIOUS 6 MONTHS TO QUALIFY FOR TMA.—Section 1925(a)(1) (42 U.S.C. 1396r–6(a)(1)) is amended by adding at the end the following: "A State may, at its option, also apply the previous sentence in the case of a family that was receiving such aid for fewer than 3 months, or that had applied for and was eligible for such aid for fewer than 3 months, during the 6 immediately preceding months described in such sentence.".

(c) ELIMINATION OF SUNSET FOR TMA.—

(1) Subsection (g) of section 1925 of such Act (42 U.S.C. 1396r–6), as redesignated under subsection (a)(2)(A), is repealed.

(2) Section 1902(e)(1) of such Act (42 U.S.C. 1396a(e)(1)) is amended by striking "(A) Notwithstanding" and all that follows through "During such period, for" in subparagraph (B) and inserting "For".

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 (42 U.S.C. 1396r–6), as amended by subsections (a)(2)(A) and (c), is amended by inserting after subsection (f) the following:

"(g) ADDITIONAL PROVISIONS.—

"(1) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—Each State shall—

"(A) collect and submit to the Secretary, in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section; and

"(B) make such information publicly available.

Such information shall be submitted under subparagraph (A) at the same time and frequency in which other enrollment information under this title is submitted to the Secretary. Using such information, the Secretary shall submit to Congress annual reports concerning such rates.".

(e) COORDINATION OF WORK.—Section 1925(g) (42 U.S.C. 1396r–6(g)), as added by subsection (d), is amended by adding at the end the following new paragraph:

"(2) COORDINATION WITH ADMINISTRATION FOR CHILDREN AND FAMILIES.—The Administrator

of the Centers for Medicare & Medicaid Services, in carrying out this section, shall work with the Assistant Secretary for the Administration for Children and Families to develop guidance or other technical assistance for States regarding best practices in guaranteeing access to transitional medical assistance under this section.''.

(f) ELIMINATION OF TMA REQUIREMENT FOR STATES THAT EXTEND COVERAGE TO CHILDREN AND PARENTS THROUGH 185 PERCENT OF POVERTY.—

(1) IN GENERAL.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is further amended by inserting after subsection (g), as added by subsection (d), the following:

''(h) PROVISIONS OPTIONAL FOR STATES THAT EXTEND COVERAGE TO CHILDREN AND PARENTS THROUGH 185 PERCENT OF POVERTY.—A State may meet (but is not required to meet) the requirements of subsections (a) and (b) if it provides for medical assistance under section 1931 to families (including both children and caretaker relatives) the average gross monthly earning of which (less such costs for such child care as is necessary for the employment of a caretaker relative) is at or below a level that is at least 185 percent of the official poverty line (as defined by the Office of Management and Budget, and re-

1 vised annually in accordance with section 673(2) of the
2 Omnibus Budget Reconciliation Act of 1981) applicable
3 to a family of the size involved.''.

4 (2) CONFORMING AMENDMENTS.—Section 1925
5 of the Social Security Act (42 U.S.C. 1396r–6) is
6 further amended, in subsections (a)(1) and (b)(1),
7 by inserting '', but subject to subsection (h),'' after
8 ''Notwithstanding any other provision of this title,''
9 each place it appears.

10 (g) REQUIREMENT OF NOTICE FOR ALL FAMILIES
11 LOSING TANF.—Subsection (a)(2) of section 1925 of
12 such Act (42 U.S.C. 1396r–6) is amended by adding at
13 the end the following flush sentences:

14 ''Each State shall provide, to families whose aid
15 under part A or E of title IV has terminated but
16 whose eligibility for medical assistance under this
17 title continues, written notice of their ongoing eligi-
18 bility for such medical assistance. If a State makes
19 a determination that any member of a family whose
20 aid under part A or E of title IV is being terminated
21 is also no longer eligible for medical assistance under
22 this title, the notice of such determination shall be
23 supplemented by a 1-page notification form describ-
24 ing the different ways in which individuals and fami-
25 lies may qualify for such medical assistance and ex-

1 plaining that individuals and families do not have to
2 be receiving aid under part A or E of title IV in
3 order to qualify for such medical assistance. Such
4 notice shall further be supplemented by information
5 on how to apply for child health assistance under the
6 State children's health insurance program under
7 title XXI and how to apply for medical assistance
8 under this title.''.

9 (h) EXTENDING USE OF OUTSTATIONED WORKERS
10 TO ACCEPT APPLICATIONS FOR TRANSITIONAL MEDICAL
11 ASSISTANCE.—Section 1902(a)(55) of the Social Security
12 Act (42 U.S.C. 1396a(a)(55)) is amended by inserting
13 ''and under section 1931'' after ''(a)(10)(A)(ii)(IX)''.

14 (i) EFFECTIVE DATES.—

15 (1) IN GENERAL.—Except as provided in this
16 subsection, the amendments made by this section
17 shall apply to calendar quarters beginning on or
18 after October 1, 2003, without regard to whether or
19 not final regulations to carry out such amendments
20 have been promulgated by such date.

21 (2) NOTICE.—The amendment made by sub-
22 section (g) shall take effect 6 months after the date
23 of enactment of this Act.

24 (3) DELAY PERMITTED FOR STATE PLAN
25 AMENDMENT.—In the case of a State plan for med-

ical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 508. ELIMINATION OF 100 HOUR RULE AND OTHER AFDC-RELATED ELIGIBILITY RESTRICTIONS.

(a) IN GENERAL.—Section 1931(b)(1)(A)(ii) of the Social Security Act (42 U.S.C. 1396u–1(b)(1)(A)(ii)) is amended by inserting ''other than the requirement that the child be deprived of parental support or care by reason of the death, continued absence from the home, incapacity, or unemployment of a parent,'' after ''section 407(a),''.

(b) CONFORMING AMENDMENT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the matter before paragraph (1), in clause (ii), by striking "if such child is (or would, if needy, be) a dependent child under part A of title IV".

(c) EFFECTIVE DATE.—The amendments made by this section apply to eligibility determinations made on or after October 1, 2003, whether or not regulations implementing such amendments have been issued.

SEC. 509. INCREASED FEDERAL REIMBURSEMENT FOR LANGUAGE SERVICES UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) MEDICAID.—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

(1) in subparagraph (D), by striking "plus" at the end and inserting "and"; and

(2) by adding at the end the following:

"(E) 90 percent of the sums expended with respect to costs incurred during such quarter as are attributable to the provision of language services, including oral interpretation, translations of written materials, and other language services, for individuals with limited English proficiency who apply for, or receive, medical assistance under the State plan; plus".

(b) SCHIP.—Section 2105(a)(1) of the Social Security Act (42 U.S.C.1397ee(a)), as amended by section 515, is amended—

(1) in the matter preceding subparagraph (A), by inserting ''or, in the case of expenditures described in subparagraph (D)(iv), 90 percent'' after ''enhanced FMAP''; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking ''and'' at the end;

(B) be redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following:

''(iv) for expenditures attributable to the provision of language services, including oral interpretation, translations of written materials, and other language services, for individuals with limited English proficiency who apply for, or receive, child health assistance under the plan; and''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 510. LIMITATIONS ON CONFLICTS OF INTEREST.

(a) LIMITATION ON CONFLICTS OF INTEREST IN MARKETING ACTIVITIES.—

(1) TITLE XXI.—Section 2105(c) of the Social Security Act (42 U.S.C. 300aa–5(c)) is amended by adding at the end the following:

"(8) LIMITATION ON EXPENDITURES FOR MARKETING ACTIVITIES.—Amounts expended by a State for the use of an administrative vendor in marketing health benefits coverage to low-income children under this title shall not be considered, for purposes of subsection (a)(2)(D), to be reasonable costs to administer the plan unless the following conditions are met with respect to the vendor:

"(A) The vendor is independent of any entity offering the coverage in the same area of the State in which the vendor is conducting marketing activities.

"(B) No person who is an owner, employee, consultant, or has a contract with the vendor either has any direct or indirect financial interest with such an entity or has been excluded from participation in the program under this title or title XVIII or XIX or debarred by any Federal agency, or subject to a civil money penalty under this Act.".

(b) PROHIBITION OF AFFILIATION WITH DEBARRED INDIVIDUALS.—

(1) MEDICAID.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i))is amended—

(A) by striking the period at the end of paragraph (20) and inserting "; or"; and

(B) by inserting after paragraph (20) the following:

"(21) with respect to any amounts expended for an entity that receives payments under the plan unless—

"(A) no person with an ownership or control interest (as defined in section 1124(a)(3)) in the entity is a person that is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulation; and

"(B) such entity has not entered into an employment, consulting, or other agreement for the provision of items or services that are material to such entity's obligations under the plan with a person described in subparagraph (A).".

(2) TITLE XXI.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as

amended by sections 505(b) and 507(b)(3), is further amended—

(A) in subparagraph (B), by striking ''and (17)'' and inserting ''(17), and (21)''; and

(B) by adding at the end the following:

''(F) Section 1902(a)(67) (relating to prohibition of affiliation with debarred individuals).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to expenditures made on or after October 1, 2003, whether or not regulations implementing such amendments have been issued.

SEC. 511. TITLE XXI FUNDING.

(a) IN GENERAL.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraphs (6) and (7), by striking ''$3,150,000,000'' each place it appears and inserting ''$4,275,000,000'';

(2) in paragraphs (8) and (9), by striking ''$4,050,000,000'' each place it appears and inserting ''$5,050,000,000'';

(3) in paragraph (9), by striking ''and'';

(4) in paragraph (10)—

(A) by striking ''$5,000,000,000'' and inserting ''$6,000,000,000''; and

(B) by striking the period and inserting a semi-colon; and

(5) by adding at the end the following new paragraph:

''(11) for fiscal year 2008 and each fiscal year thereafter, the amount of the allotment provided under this subsection for the preceding fiscal year increased by the percentage increase (if any) in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average).''.

(b) ADDITIONAL ALLOTMENT TO TERRITORIES.—Section 2104(c)(4)(B) of the Social Security Act (42 U.S.C. 1397dd(c)(4)(B)) is amended to read as follows:

''(B) APPROPRIATIONS.—For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated, $32,000,000 for fiscal year 1999, $40,000,000 for each of fiscal years 2000 through 2004, $50,000,000 for each of fiscal years 2005, 2006 and 2007, and for fiscal year 2008 and each fiscal year thereafter, the amount under this paragraph for the preceding fiscal year increased by the percentage increase (if any) in

the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average).''.

(c) EFFECTIVE DATE.—This section, and the amendments made by this section, shall be effective as if this section had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) from allotments for fiscal years beginning with fiscal year 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this section as if this section had been enacted on September 30, 2002.

SEC. 512. CHANGES TO RULES FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF TITLE XXI FISCAL YEAR 2000 AND SUBSEQUENT FISCAL YEAR ALLOTMENTS.

(a) IN GENERAL.—Section 2104(g) of the Social Security Act (42 U.S.C. 1397dd(g)) is amended—

(1) in the subsection heading—

(A) by striking ''AND'' after ''1998'' and inserting a comma; and

(B) by inserting '', AND 2000 AND SUBSEQUENT FISCAL YEAR'' after ''1999'';

(2) in paragraph (1)—

(A) in subparagraph (A)—

(i) in the matter preceding clause (i)—

(I) by inserting ''or for fiscal year 2000 by the end of fiscal year 2002, or allotments for fiscal year 2001 and subsequent fiscal years by the end of the last fiscal year for which such allotments are available under subsection (e), subject to paragraph (2)(C)'' after ''2001,''; and

(II) by striking ''1998 or 1999'' and inserting ''1998, 1999, 2000, or subsequent fiscal year'';

(ii) in clause (i)—

(I) in subclause (I), by striking ''or'' at the end;

(II) in subclause (II), by striking the period and inserting a semicolon; and

(III) by adding at the end the following:

''(III) the fiscal year 2000 allotment, the amount by which the State's expenditures under this title in fiscal years 2000, 2001, and 2002 ex-

ceed the State's allotment for fiscal year 2000 under subsection (b);

"(IV) the fiscal year 2001 allotment, the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); or

"(V) the allotment for any subsequent fiscal year, the amount by which the State's expenditures under this title in the period such allotment is available under subsection (e) exceeds the State's allotment for that fiscal year under subsection (b)."; and

(iii) in clause (ii), by striking "1998 or 1999 allotment" and inserting "1998, 1999, 2000, or subsequent fiscal year allotment";

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by striking "with respect to fiscal year 1998 or 1999";

(ii) in clause (ii)—

(I) by inserting ''with respect to fiscal year 1998 or 1999,'' after ''subsection (e)''; and

(II) by striking ''and'' at the end;

(iii) by redesignating clause (iii) as clause (iv); and

(iv) by inserting after clause (ii), the following:

''(iii) notwithstanding subsection (e), with respect to fiscal year 2000 or any subsequent fiscal year, shall remain available for expenditure by the State through the end of the fiscal year in which the State is allotted a redistribution under this paragraph; and'';

(3) in paragraph (2)—

(A) in the paragraph heading, by striking ''1998 AND 1999'' and inserting ''1998, 1999, 2000, AND SUBSEQUENT FISCAL YEAR'';

(B) in subparagraph (A), by adding at the end the following:

''(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State

by the end of fiscal year 2002, the amount specified in subparagraph (B) for fiscal year 2000 for such State shall remain available for expenditure by the State through the end of fiscal year 2003.

"(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, the amount specified in subparagraph (B) for fiscal year 2001 for such State shall remain available for expenditure by the State through the end of 2004.

"(v) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—Of the amounts allotted to a State pursuant to this section for any fiscal year after 2001, that were not expended by the State by the end of the last fiscal year such amounts are available under subsection (e), the amount specified in subparagraph (B) for that fiscal year for such State shall remain available for expenditure by the State through the end of the fiscal year following the last fiscal

year such amounts are available under subsection (e).'';

(C) in subparagraph (B), by striking ''The'' and inserting ''Subject to subparagraph (C), the'';

(D) by redesignating subparagraph (C) as subparagraph (D); and

(E) by inserting after subparagraph (B), the following:

''(C) FLOOR FOR FISCAL YEARS 2000 AND 2001.—For fiscal years 2000 and 2001, if the total amounts that would otherwise be redistributed under paragraph (1) exceed 60 percent of the total amount available for redistribution under subsection (f) for the fiscal year, the amount remaining available for expenditure by the State under subparagraph (A) for such fiscal years shall be—

''(i) the amount equal to—

''(I) 40 percent of the total amount available for redistribution under subsection (f) from the allotments for the applicable fiscal year; multiplied by

"(II) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount available for redistribution under subsection (f) from the allotments for the fiscal year."; and

(4) in paragraph (3), by adding at the end the following: "For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for any fiscal year after 1999, the Secretary shall use the amount reported by the States not later than November 30 of the applicable calendar year on HCFA Form 64 or HCFA Form 21, as approved by the Secretary.".

(b) ESTABLISHMENT OF CASELOAD STABILIZATION POOL AND ADDITIONAL REDISTRIBUTION OF ALLOTMENTS.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following:

"(h) REDISTRIBUTION OF CASELOAD STABILIZATION POOL AMOUNTS.—

"(1) ADDITIONAL REDISTRIBUTION TO STABILIZE CASELOADS.—

"(A) IN GENERAL.—With respect to fiscal year 2003 and any subsequent fiscal year, the

Secretary shall redistribute to an eligible State (as defined in subparagraph (B)) the amount available for redistribution to the State (as determined under subparagraph (C)) from the caseload stabilization pool established under paragraph (3).

"(B) DEFINITION OF ELIGIBLE STATE.—For purposes of subparagraph (A), an eligible State is a State whose total expenditures under this title through the end of the previous fiscal year exceed the total allotments made available to the State under subsection (b) or subsection (c) (not including amounts made available under subsection (f)) through the previous fiscal year.

"(C) AMOUNT OF ADDITIONAL REDISTRIBUTION.—For purposes of subparagraph (A), the amount available for redistribution to a State under subparagraph (A) is equal to—

"(i) the ratio of the State's allotment for the previous fiscal year under subsection (b) or subsection (c) to the total allotments made available under such subsections to eligible States as defined under

subparagraph (A) for the previous fiscal year; multiplied by

"(ii) the total amounts available in the caseload stabilization pool established under paragraph (3).

"(2) PERIOD OF AVAILABILITY.—Amounts redistributed under this subsection shall remain available for expenditure by the State through the end of the fiscal year in which the State receives any such amounts.

"(3) CASELOAD STABILIZATION POOL.—For purposes of making a redistribution under paragraph (1), the Secretary shall establish a caseload stabilization pool that includes the following amounts:

"(A) Any amount made available to a State under subsection (g) but not expended within the periods required under subparagraphs (g)(1)(B)(ii), (g)(1)(B)(iii), or (g)(2)(A).

"(B) Any amount made available to a State under this subsection but not expended within the period required under paragraph (2).".

1 (c) AUTHORITY FOR QUALIFYING STATES TO USE
2 PORTION OF SCHIP FUNDS FOR MEDICAID EXPENDI-
3 TURES.—Section 2105 of the Social Security Act (42
4 U.S.C. 1397ee) is amended by adding at the end the fol-
5 lowing:
6 "(g) AUTHORITY FOR QUALIFYING STATES TO USE
7 CERTAIN FUNDS FOR MEDICAID EXPENDITURES.—
8 "(1) STATE OPTION.—
9 "(A) IN GENERAL.—Notwithstanding any
10 other provision of law, with respect to fiscal
11 year 2003 and each fiscal year thereafter, a
12 qualifying State (as defined in paragraph (2))
13 may elect to use not more than 20 percent of
14 the amount allotted to the State under sub-
15 section (b) or (c) of section 2104 for the fiscal
16 year (instead of for expenditures under this
17 title) for payments for such fiscal year under
18 title XIX in accordance with subparagraph (B).
19 "(B) PAYMENTS TO STATES.—
20 "(i) IN GENERAL.—In the case of a
21 qualifying State that has elected the option
22 described in subparagraph (A), subject to
23 the total amount of funds described with
24 respect to the State in subparagraph (A),
25 the Secretary shall pay the State an

1 amount each quarter equal to the addi-
2 tional amount that would have been paid
3 to the State under title XIX for expendi-
4 tures of the State for the fiscal year de-
5 scribed in clause (ii) if the enhanced
6 FMAP (as determined under subsection
7 (b)) had been substituted for the Federal
8 medical assistance percentage (as defined
9 in section 1905(b)) of such expenditures.
10 ''(ii) EXPENDITURES DESCRIBED.—
11 For purposes of clause (i), the expendi-
12 tures described in this clause are expendi-
13 tures for such fiscal years for providing
14 medical assistance under title XIX to indi-
15 viduals who have not attained age 19 and
16 whose family income exceeds 150 percent
17 of the poverty line.
18 ''(2) QUALIFYING STATE.—In this subsection,
19 the term 'qualifying State' means a State that—
20 ''(A) as of March 31, 1997, has an income
21 eligibility standard with respect to any 1 or
22 more categories of children (other than infants)
23 who are eligible for medical assistance under
24 section 1902(a)(10)(A) that is at least 185 per-
25 cent of the poverty line; and

1 "(B) satisfies the requirements described
2 in paragraph (3).
3 "(3) REQUIREMENTS.—The requirements de-
4 scribed in this paragraph are the following:
5 "(A) SCHIP INCOME ELIGIBILITY.—The
6 State has a State child health plan that (wheth-
7 er implemented under title XIX or this title)—
8 "(i) as of January 1, 2003, has an in-
9 come eligibility standard that is at least
10 200 percent of the poverty line;
11 "(ii) subject to subparagraph (B),
12 does not limit the acceptance of applica-
13 tions for children; and
14 "(iii) provides benefits to all children
15 in the State who apply for and meet eligi-
16 bility standards on a statewide basis.
17 "(B) NO WAITING LIST IMPOSED.—With
18 respect to children whose family income is at or
19 below 200 percent of the poverty line, the State
20 does not impose any numerical limitation, wait-
21 ing list, or similar limitation on the eligibility of
22 such children for child health assistance under
23 such State plan.
24 "(C) ADDITIONAL REQUIREMENTS.—The
25 State has implemented at least 4 of the fol-

lowing policies and procedures (relating to coverage of children under title XIX and this title):

"(i) UNIFORM, SIMPLIFIED APPLICATION FORM.—With respect to children who are eligible for medical assistance under section 1902(a)(10)(A), the State uses the same uniform, simplified application form (including, if applicable, permitting application other than in person) for purposes of establishing eligibility for benefits under title XIX and this title.

"(ii) ELIMINATION OF ASSET TEST.—The State does not apply any asset test for eligibility under section 1902(l) or this title with respect to children.

"(iii) ADOPTION OF 12-MONTH CONTINUOUS ENROLLMENT.—The State provides that eligibility shall not be regularly redetermined more often than once every year under this title or for children described in section 1902(a)(10)(A).

"(iv) SAME VERIFICATION AND REDETERMINATION POLICIES; AUTOMATIC REASSESSMENT OF ELIGIBILITY.—With respect to children who are eligible for medical as-

sistance under section 1902(a)(10)(A), the State provides for initial eligibility determinations and redeterminations of eligibility using the same verification policies (including with respect to face-to-face interviews), forms, and frequency as the State uses for such purposes under this title, and, as part of such redeterminations, provides for the automatic reassessment of the eligibility of such children for assistance under title XIX and this title.

"(v) OUTSTATIONING ENROLLMENT STAFF.—The State provides for the receipt and initial processing of applications for benefits under this title and for children under title XIX at facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(l)(2)(B) consistent with section 1902(a)(55).".

(d) EFFECTIVE DATE.—This section, and the amendments made by this section, shall be effective as if this section had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42

U.S.C. 1397aa et seq.) from allotments for fiscal years 1998 through 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this section as if this section had been enacted on September 30, 2002.

SEC. 513. DEMONSTRATION PROGRAMS TO IMPROVE MEDICAID AND TITLE XXI OUTREACH TO HOMELESS INDIVIDUALS AND FAMILIES.

(a) AUTHORITY.—The Secretary of Health and Human Services may award demonstration grants to not more than 7 States (or other qualified entities) to conduct innovative programs that are designed to improve outreach to homeless individuals and families under the programs described in subsection (b) with respect to enrollment of such individuals and families under such programs and the provision of services (and coordinating the provision of such services) under such programs.

(b) PROGRAMS FOR HOMELESS DESCRIBED.—The programs described in this subsection are as follows:

(1) MEDICAID.—The program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) CHIP.—The program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(3) TANF.—The program under part of A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(4) SAMHSA BLOCK GRANTS.—The program of grants under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–1 et seq.).

(5) FOOD STAMP PROGRAM.—The program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(6) WORKFORCE INVESTMENT ACT.—The program under the Workforce Investment Act of 1999 (29 U.S.C. 2801 et seq.).

(7) WELFARE-TO-WORK.—The welfare-to-work program under section 403(a)(5) of the Social Security Act (42 U.S.C. 603(a)(5)).

(8) OTHER PROGRAMS.—Other public and private benefit programs that serve low-income individuals.

(c) APPROPRIATIONS.—For the purposes of carrying out this section, there is appropriated for fiscal year 2004, out of any funds in the Treasury not otherwise appropriated, $10,000,000, to remain available until expended.

SEC. 514. TECHNICAL AND CONFORMING AMENDMENTS TO AUTHORITY TO PAY MEDICAID EXPANSION COSTS FROM TITLE XXI APPROPRIATION.

(a) AUTHORITY TO PAY MEDICAID EXPANSION COSTS FROM TITLE XXI APPROPRIATION.—Section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)) is amended to read as follows:

"(a) ALLOWABLE EXPENDITURES.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP of the following expenditures in the quarter:

"(A) CHILD HEALTH ASSISTANCE UNDER MEDICAID.—Expenditures for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for expenditures described in the fourth sentence of section 1905(b).

"(B) RESERVED.—[reserved].

"(C) CHILD HEALTH ASSISTANCE UNDER THIS TITLE.—Expenditures for child health assistance under the plan for targeted low-income children in the form of providing health benefits

coverage that meets the requirements of section 2103.

"(D) ASSISTANCE AND ADMINISTRATIVE EXPENDITURES SUBJECT TO LIMIT.—Expenditures only to the extent permitted consistent with subsection (c)—

"(i) for other child health assistance for targeted low-income children;

"(ii) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

"(iii) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

"(iv) for other reasonable costs incurred by the State to administer the plan.

"(2) ORDER OF PAYMENTS.—Payments under a subparagraph of paragraph (1) from a State's allotment for expenditures described in each such subparagraph shall be made on a quarterly basis in the order of such subparagraph in such paragraph.

"(3) NO DUPLICATIVE PAYMENT.—In the case of expenditures for which payment is made under

paragraph (1), no payment shall be made under title XIX.''.

(b) CONFORMING AMENDMENTS.—

(1) SECTION 1905(u).—Section 1905(u)(1)(B) of the Social Security Act (42 U.S.C. 1396d(u)(1)(B)) is amended by inserting ''and section 2105(a)(1)'' after ''subsection (b)''.

(2) SECTION 2105(c).—Section 2105(c)(2)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(2)(A)) is amended by striking ''subparagraphs (A), (C), and (D) of''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251), whether or not regulations implementing such amendments have been issued.

SEC. 515. ADDITIONAL TITLE XXI REVISIONS.

(a) LIMITING COST-SHARING TO 2.5 PERCENT FOR FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY.—Section 2103(e)(3)(A) of the Social Security Act (42 U.S.C. 1397cc(e)(3)(A)) is amended—

(1) by striking ''and'' at the end of clause (i);

(2) by striking the period at the end of clause (ii) and inserting ''; and''; and

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

"(iii) total annual aggregate cost-sharing described in clauses (i) and (ii) with respect to all such targeted low-income children in a family under this title that exceeds 2.5 percent of such family's income for the year involved.".

(b) REPORTING OF ENROLLMENT DATA.—

(1) QUARTERLY REPORTS.—Section 2107(b)(1) of such Act (42 U.S.C. 1397gg(b)(1)) is amended by adding at the end the following: "In quarterly reports on enrollment required under this paragraph, a State shall include information on the age, gender, race, ethnicity, service delivery system, and family income of individuals enrolled.".

(2) ANNUAL REPORTS.—Section 2108(b)(1)(B)(i) of such Act (42 U.S.C. 1397hh(b)(1)(B)(i)) is amended by inserting "primary language of enrollees," after "family income,".

(c) EMPLOYER COVERAGE WAIVER CHANGES.—Section 2105(c)(3) of such Act (42 U.S.C. 1397ee(c)(3)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii) and indenting appropriately;

(2) by designating the matter beginning with "Payment may be made" as a subparagraph (A) with the heading "IN GENERAL" and indenting appropriately; and

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

"(B) APPLICATION OF REQUIREMENTS.—In carrying out subparagraph (A)—

"(i) the Secretary shall not require a minimum employer contribution level that is separate from the requirement of cost-effectiveness under subparagraph (A)(i), but a State shall identify a reasonable minimum employer contribution level that is based on data demonstrating that such a level is representative to the employer-sponsored insurance market in the State and shall monitor employer contribution levels over time to determine whether substitution is occurring and report the findings in annual reports under section 2108(a);

1 "(ii) the State shall establish a wait-
2 ing period of at least 6 months without
3 group health coverage, but may establish
4 reasonable exceptions to such period and
5 shall not apply such a waiting period to a
6 child who is provided coverage under a
7 group health plan under section 1906;
8 "(iii) subject to clause (iv), the State
9 shall provide satisfactory assurances that
10 the minimum benefits and cost-sharing
11 protections established under this title are
12 provided, either through the coverage
13 under subparagraph (A) or as a supple-
14 ment to such coverage; and
15 "(iv) coverage under such subpara-
16 graph shall not be considered to violate
17 clause (iii) because it does not comply with
18 requirements relating to reviews of health
19 service decisions if the enrollee involved is
20 provided the option of being provided bene-
21 fits directly under this title.
22 "(C) ACCESS TO EXTERNAL REVIEW PROC-
23 ESS.—In carrying out subparagraph (A), if a
24 State provides coverage under a group health
25 plan that does not meet the following external

1 review requirements, the State must give appli-
2 cants and enrollees (at initial enrollment and at
3 each redetermination of eligibility) the option to
4 obtain health benefits coverage other than
5 through that group health plan:
6 ''(i) The enrollee has an opportunity
7 for external review of a—
8 ''(I) delay, denial, reduction, sus-
9 pension, or termination of health serv-
10 ices, in whole or in part, including a
11 determination about the type or level
12 of services; and
13 ''(II) failure to approve, furnish,
14 or provide payment for health services
15 in a timely manner.
16 ''(ii) The external review is conducted
17 by the State or a impartial contractor
18 other than the contractor responsible for
19 the matter subject to external review.
20 ''(iii) The external review decision is
21 made on a timely basis in accordance with
22 the medical needs of the patient. If the
23 medical needs of the patient do not dictate
24 a shorter time frame, the review must be
25 completed—

"(I) within 90 calendar days of the date of the request for internal or external review; or

"(II) within 72 hours if the enrollee's physician or plan determines that the deadline under subclause (I) could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function (except that a State may extend the 72-hour deadline by up to 14 days if the enrollee requests an extension).

"(iv) The external review decision shall be in writing.

"(v) Applicants and enrollees have an opportunity—

"(I) to represent themselves or have representatives of their choosing in the review process;

"(II) timely review their files and other applicable information relevant to the review of the decision; and

"(III) fully participate in the review process, whether the review is conducted in person or in writing, in-

cluding by presenting supplemental information during the review process.''.

(d) EFFECTIVE DATE.—The amendments made by this section apply as of October 1, 2003, whether or not regulations implementing such amendments have been issued.

TITLE VI—FAMILY OPPORTUNITY

SEC. 601. OPPORTUNITY FOR FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN

(a) STATE OPTION TO ALLOW FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.—

(1) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 502(a)(1)(A), is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) by striking ''or'' at the end of subclause (XVIII);

(ii) by adding ''or'' at the end of subclause (XIX); and

(iii) by adding at the end the following new subclause:

"(XX) who are disabled children described in subsection (cc)(1);"; and

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

"(cc)(1) Individuals described in this paragraph are individuals—

"(A) who have not attained 18 years of age;

"(B) who would be considered disabled under section 1614(a)(3)(C) but for having earnings or deemed income or resources (as determined under title XVI for children) that exceed the requirements for receipt of supplemental security income benefits; and

"(C) whose family income does not exceed such income level as the State establishes and does not exceed—

"(i) 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

"(ii) such higher percent of such poverty line as a State may establish, except that—

"(I) any medical assistance provided to an individual whose family income exceeds 250 percent of such poverty line may only be provided with State funds; and

"(II) no Federal financial participation shall be provided under section 1903(a) for any medical assistance provided to such an individual.".

(2) INTERACTION WITH EMPLOYER-SPONSORED FAMILY COVERAGE.—Section 1902(cc) of Social Security Act (42 U.S.C. 1396a(cc)), as added by paragraph (1)(B), is amended by adding at the end the following new paragraph:

"(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act), the State shall—

"(i) require such parent to apply for, enroll in, and pay premiums for, such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

"(ii) if such coverage is obtained—

"(I) subject to paragraph (2) of section 1916(h), reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

"(II) treat such coverage as a third party liability under subsection (a)(25).

"(B) In the case of a parent to which subparagraph (A) applies, a State, subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.".

(b) STATE OPTION TO IMPOSE INCOME-RELATED PREMIUMS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(1) in subsection (a), by striking "subsection (g)" and inserting "subsections (g) and (h)"; and

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

"(h)(1) With respect to disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XX),

1 subject to paragraph (2), a State may (in a uniform man-
2 ner for such children) require the families of such children
3 to pay monthly premiums set on a sliding scale based on
4 family income.

5 ''(2) A premium requirement imposed under para-
6 graph (1) may only apply to the extent that—

7 ''(A) the aggregate amount of such premium
8 and any premium that the parent is required to pay
9 for family coverage under section 1902(cc)(2)(A)(i)
10 does not exceed 5 percent of the family's income;
11 and

12 ''(B) the requirement is imposed consistent with
13 section 1902(cc)(2)(A)(ii)(I).

14 ''(3) A State shall not require prepayment of a pre-
15 mium imposed pursuant to paragraph (1) and shall not
16 terminate eligibility of a child under section
17 1902(a)(10)(A)(ii)(XX) for medical assistance under this
18 title on the basis of failure to pay any such premium until
19 such failure continues for a period of not less than 60 days
20 from the date on which the premium became past due.
21 The State may waive payment of any such premium in
22 any case where the State determines that requiring such
23 payment would create an undue hardship.''.

24 (c) CONFORMING AMENDMENTS.—Section
25 1903(f)(4) of the Social Security Act (42 U.S.C.

1396b(f)(4)), as amended by section 502(c)(2) is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 2004.

SEC. 602. TREATMENT OF INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER AGE 21 IN HOME OR COMMUNITY-BASED SERVICES WAIVERS.

(a) IN GENERAL.—Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended—

(1) in paragraph (1)—

(A) in the first sentence, by inserting '', or would require inpatient psychiatric hospital services for individuals under age 21,'' after ''intermediate care facility for the mentally retarded''; and

(B) in the second sentence, by inserting '', or would require inpatient psychiatric hospital services for individuals under age 21'' before the period;

(2) in paragraph (2)(B), by striking ''or services in an intermediate care facility for the mentally

retarded'' each place it appears and inserting ''services in an intermediate care facility for the mentally retarded, or inpatient psychiatric hospital services for individuals under age 21'';

(3) in paragraph (2)(C)—

(A) by inserting '', or who are determined to be likely to require inpatient psychiatric hospital services for individuals under age 21,'' after '', or intermediate care facility for the mentally retarded''; and

(B) by striking ''or services in an intermediate care facility for the mentally retarded'' and inserting ''services in an intermediate care facility for the mentally retarded, or inpatient psychiatric hospital services for individuals under age 21''; and

(4) in paragraph (7)(A)—

(A) by inserting ''or would require inpatient psychiatric hospital services for individuals under age 21,'' after ''intermediate care facility for the mentally retarded,''; and

(B) by inserting ''or who would require inpatient psychiatric hospital services for individuals under age 21'' before the period.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to medical assistance provided on or after January 1, 2004.

SEC. 603. DEVELOPMENT AND SUPPORT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501 of the Social Security Act (42 U.S.C. 701) is amended by adding at the end the following new subsection:

"(c)(1)(A) For the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance for the development and support of family-to-family health information centers described in paragraph (2)—

"(i) there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated—

"(I) $3,000,000 for fiscal year 2003;

"(II) $4,000,000 for fiscal year 2004; and

"(III) $5,000,000 for fiscal year 2005; and

"(ii) there is authorized to be appropriated to the Secretary, $5,000,000 for each of fiscal years 2006 and 2007.

"(B) Funds appropriated or authorized to be appropriated under subparagraph (A) shall—

1 "(i) be in addition to amounts appropriated
2 under subsection (a) and retained under section
3 502(a)(1) for the purpose of carrying out activities
4 described in subsection (a)(2); and
5 "(ii) remain available until expended.
6 "(2) The family-to-family health information centers
7 described in this paragraph are centers that—
8 "(A) assist families of children with disabilities
9 or special health care needs to make informed
10 choices about health care in order to promote good
11 treatment decisions, cost-effectiveness, and improved
12 health outcomes for such children;
13 "(B) provide information regarding the health
14 care needs of, and resources available for, children
15 with disabilities or special health care needs;
16 "(C) identify successful health delivery models
17 for such children;
18 "(D) develop with representatives of health care
19 providers, managed care organizations, health care
20 purchasers, and appropriate State agencies a model
21 for collaboration between families of such children
22 and health professionals;
23 "(E) provide training and guidance regarding
24 caring for such children;

"(F) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals; and

"(G) are staffed by families of children with disabilities or special health care needs who have expertise in Federal and State public and private health care systems and health professionals.

"(3) The Secretary shall develop family-to-family health information centers described in paragraph (2) under this subsection in accordance with the following:

"(A) With respect to fiscal year 2003, such centers shall be developed in not less than 25 States.

"(B) With respect to fiscal year 2004, such centers shall be developed in not less than 40 States.

"(C) With respect to fiscal year 2005, such centers shall be developed in not less than 50 States and the District of Columbia.

"(4) The provisions of this title that are applicable to the funds made available to the Secretary under section 502(a)(1) apply in the same manner to funds made available to the Secretary under paragraph (1)(A).

"(5) For purposes of this subsection, the term 'State' means each of the 50 States and the District of Columbia.".

SEC. 604. RESTORATION OF MEDICAID ELIGIBILITY FOR CERTAIN SSI BENEFICIARIES.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended—

(1) by inserting ''(aa)'' after ''(II)'';

(2) by striking '') and'' and inserting ''and'';

(3) by striking ''section or who are'' and inserting ''section), (bb) who are''; and

(4) by inserting before the comma at the end the following: '', or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(c)(7) were applied without regard to the phrase 'the first day of the month following' ''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance for items and services furnished on or after the first day of the first calendar quarter that begins after the date of enactment of this Act.

TITLE VII—TEMPORARY STATE FISCAL RELIEF

SEC. 701. TEMPORARY STATE FISCAL RELIEF.

(a) PERMITTING MAINTENANCE OF FISCAL YEAR 2002 FMAP FOR LAST 2 CALENDAR QUARTERS OF FIS-

1 CAL YEAR 2003.—Notwithstanding any other provision of
2 law, but subject to subsection (e), if the FMAP deter-
3 mined without regard to this section for a State for fiscal
4 year 2003 is less than the FMAP as so determined for
5 fiscal year 2002, the FMAP for the State for fiscal year
6 2002 shall be substituted for the State's FMAP for the
7 third and fourth calendar quarters of fiscal year 2003, be-
8 fore the application of this section.

9 (b) PERMITTING MAINTENANCE OF FISCAL YEAR
10 2003 FMAP FOR FISCAL YEAR 2004.—Notwithstanding
11 any other provision of law, but subject to subsection (e),
12 if the FMAP determined without regard to this section
13 for a State for fiscal year 2004 is less than the FMAP
14 as so determined for fiscal year 2003, the FMAP for the
15 State for fiscal year 2003 shall be substituted for the
16 State's FMAP for each calendar quarter of fiscal year
17 2004, before the application of this section.

18 (c) GENERAL 2.38 PERCENTAGE POINTS INCREASE
19 FOR LAST 2 CALENDAR QUARTERS OF FISCAL YEAR 2003
20 AND FISCAL YEAR 2004.—Notwithstanding any other
21 provision of law, but subject to subsections (e) and (f),
22 for each State for the third and fourth calendar quarters
23 of fiscal year 2003 and each calendar quarter of fiscal year
24 2004, the FMAP (taking into account the application of

1 subsections (a) and (b)) shall be increased by 2.38 per-
2 centage points.

3 (d) INCREASE IN CAP ON MEDICAID PAYMENTS TO
4 TERRITORIES.—Notwithstanding any other provision of
5 law, but subject to subsection (f), with respect to the third
6 and fourth calendar quarters of fiscal year 2003 and each
7 calendar quarter of fiscal year 2004, the amounts other-
8 wise determined for Puerto Rico, the Virgin Islands,
9 Guam, the Northern Mariana Islands, and American
10 Samoa under subsections (f) and (g) of section 1108 of
11 the Social Security Act (42 U.S.C. 1308) shall each be
12 increased by an amount equal to 4.76 percent of such
13 amounts.

14 (e) SCOPE OF APPLICATION.—The increases in the
15 FMAP for a State under this section shall apply only for
16 purposes of title XIX of the Social Security Act and shall
17 not apply with respect to—

18 (1) disproportionate share hospital payments
19 described in section 1923 of such Act (42 U.S.C.
20 1396r–4); or

21 (2) payments under title IV or XXI of such Act
22 (42 U.S.C. 601 et seq. and 1397aa et seq.).

23 (f) STATE ELIGIBILITY.—

24 (1) IN GENERAL.—Subject to paragraph (2), a
25 State is eligible for an increase in its FMAP under

subsection (c) or an increase in a cap amount under subsection (d) only if the eligibility under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) is no more restrictive than the eligibility under such plan (or waiver) as in effect on January 1, 2003.

(2) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—A State that has restricted eligibility under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after January 1, 2003, but prior to the date of enactment of this Act is eligible for an increase in its FMAP under subsection (c) or an increase in a cap amount under subsection (d) in the first calendar quarter (and subsequent calendar quarters) in which the State has reinstated eligibility that is no more restrictive than the eligibility under such plan (or waiver) as in effect on January 1, 2003.

(3) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or (2) shall be construed as affecting a State's flexibility with respect to benefits offered under the State medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)

(including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)).

(g) DEFINITIONS.—In this section:

(1) FMAP.—The term ''FMAP'' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(2) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(h) REPEAL.—Effective as of October 1, 2004, this subsection is repealed.

TITLE VIII—IMPROVEMENT OF THE PROCESS FOR THE DEVELOPMENT AND IMPLEMENTATION OF MEDICAID AND SCHIP WAIVERS

SEC. 801. IMPROVEMENT OF THE PROCESS FOR THE DEVELOPMENT AND IMPLEMENTATION OF MEDICAID AND SCHIP WAIVERS.

(a) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

''(d) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to as-

1 sist in promoting the objectives of title XIX or XXI in
2 a State that would result in a nontrivial impact on eligi-
3 bility, enrollment, benefits, cost-sharing, or financing with
4 respect to a State program under title XIX or XXI (in
5 this subsection referred to as a 'medicaid waiver' and a
6 'SCHIP waiver', respectively,) the following shall apply:
7 "(1) The Secretary may not approve a proposal
8 for a medicaid waiver, SCHIP waiver, or an amend-
9 ment to a previously approved medicaid waiver or
10 SCHIP waiver unless the State requesting approval
11 certifies that the following process was used to de-
12 velop the proposal:
13 "(A) Prior to publication of the notice re-
14 quired under subparagraph (B), the State—
15 "(i) provided notice (which may have
16 been accomplished by electronic mail) of
17 the State's intent to develop the proposal
18 to the medical care advisory committee es-
19 tablished for the State for purposes of
20 complying with section 1902(a)(4) and any
21 individual or organization that requests
22 such notice; and
23 "(ii) convened at least 1 meeting of
24 such medical care advisory committee at
25 which the proposal and any modifications

of the proposal were considered and discussed.

"(B) At least 60 days prior to the date that the State submits the proposal to the Secretary, the State published for written comment (in accordance with the State's procedure for issuing regulations) a notice of the proposal that contains at least the following:

"(i) Information regarding how the public may submit comments to the State on the proposal.

"(ii) A statement of the State's projections regarding the likely effect and impact of the proposal on any individuals who are eligible for, or receiving, medical assistance, child health assistance, or other health benefits coverage under a State program under title XIX or XXI and the State's assumptions on which such projections are based.

"(iii) A statement of the State's projections regarding the likely effect and impact of the proposal on any providers or suppliers of items or services for which payment may be made under title XIX or

XXI and the State's assumptions on which such projections are based.

"(C) Concurrent with the publication of the notice required under subparagraph (B), the State—

"(i) posted the proposal (and any modifications of the proposal) on the State's Internet website; and

"(ii) provided the notice (which may have been accomplished by electronic mail) to the medical care advisory committee referred to in subparagraph (A)(i) and to any individual or organization that requested such notice.

"(D) Not later than 30 days after publication of the notice required under subparagraph (B), the State convened at least 1 open meeting of the medical care advisory committee referred to in subparagraph (A)(i), at which the proposal and any modifications of the proposal were the primary items considered and discussed.

"(E) After publication of the notice required under subparagraph (B), the State—

"(i) held at least 2 public hearings on the proposal and any modifications of the proposal; and

"(ii) held the last such public hearing at least 15 days before the State submitted the proposal to the Secretary.

"(F) The State has a record of all public comments submitted in response to the notice required under subparagraph (B) or at any hearings or meetings required under this paragraph regarding the proposal.

"(2) A State shall include with any proposal submitted to the Secretary for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver the following:

"(A) A detailed description of the public notice and input process used to develop the proposal in accordance with the requirements of paragraph (1).

"(B) Copies of all notices required under paragraph (1).

"(C) The dates of all meetings and hearings required under paragraph (1).

"(D) A summary of the public comments received in response to the notices required under paragraph (1) or at any hearings or meetings required under that paragraph regarding the proposal and the State's response to the comments.

"(E) A certification that the State complied with any applicable notification requirements with respect to Indian tribes during the development of the proposal in accordance with paragraph (1).

"(3) The Secretary shall return to a State without action any proposal for a medicaid waiver, SCHIP waiver, or an amendment to a previously approved medicaid waiver or SCHIP waiver that fails to satisfy the requirements of paragraphs (1) and (2).

"(4) With respect to all proposals for medicaid waivers, SCHIP waivers, or amendments to a previously approved medicaid waiver or SCHIP waiver received by the Secretary the following shall apply:

"(A) Each month the Secretary shall publish a notice in the Federal Register identifying all of the proposals for such waivers or amend-

1 ments that were received by the Secretary dur-
2 ing the preceding month.
3 "(B) The notice required under subpara-
4 graph (A) shall provide information regarding
5 the method by which comments on the pro-
6 posals will be received from the public.
7 "(C) Not later than 7 days after receipt of
8 a proposal for a medicaid waiver, SCHIP waiv-
9 er, or an amendment to a previously approved
10 medicaid waiver or SCHIP waiver, the Sec-
11 retary shall—
12 "(i) provide notice (which may be ac-
13 complished by electronic mail) to any indi-
14 vidual or organization that has requested
15 such notification;
16 "(ii) publish on the Internet website
17 of the Centers for Medicare & Medicaid
18 Services a copy of the proposal, including
19 any appendices or modifications of the pro-
20 posal; and
21 "(iii) ensure that the information
22 posted on the website is updated to accu-
23 rately reflect the proposal.
24 "(D) The Secretary shall provide for a pe-
25 riod of not less than 30 days from the later of

the date of publication of the notice required under subparagraph (A) that first identifies receipt of the proposal or the date on which an Internet website containing the information required under subparagraph (C)(ii) with respect to the proposal is first published, in which written comments on the proposal may be submitted from all interested parties.

"(E) After the completion of the public comment period required under subparagraph (D), if the Secretary intends to approve the proposal, as originally submitted or revised, the Secretary shall—

"(i) publish and post on the Internet website for the Centers for Medicare & Medicaid Services the proposed terms and conditions for such approval and updated versions of the statements required to be published by the State under clauses (ii) and (iii) of paragraph (1)(B);

"(ii) provide at least a 15-day period for the submission of written comments on such proposed terms and conditions and such statements; and

1 "(iii) retain, and make available upon
2 request, all comments received concerning
3 the proposal, the terms and conditions for
4 approval of the proposal, or such state-
5 ments.
6 "(F) In no event may the Secretary ap-
7 prove or deny a proposal for a medicaid waiver,
8 SCHIP waiver, or an amendment to a pre-
9 viously approved medicaid waiver or SCHIP
10 waiver until the Secretary—
11 "(i) reviews and considers all com-
12 ments submitted in response to the notices
13 required under this paragraph; and
14 "(ii) considers the nature and impact
15 of the proposal; and
16 "(iii) determines that the proposal—
17 "(I) is based on a reasonable hy-
18 pothesis which the proposal is de-
19 signed to test in a methodologically
20 sound manner; and
21 "(II) will be evaluated on a year-
22 ly basis utilizing a sound methodology
23 to determine whether the proposal has
24 resulted in a change in access to
25 health care or in health outcomes for

1 any beneficiaries of medical assist-
2 ance, child health assistance, or other
3 health benefits coverage whose assist-
4 ance or coverage would be altered as
5 a result of the proposal.

6 ''(G) Not later than 3 days after the ap-
7 proval of any proposal for a medicaid waiver,
8 SCHIP waiver, or amendment to a previously
9 approved medicaid waiver or SCHIP waiver, the
10 Secretary shall post on the Internet website for
11 the Centers for Medicare & Medicaid Services
12 the following:

13 ''(i) The text of the approved med-
14 icaid waiver, SCHIP waiver, or amendment
15 to a previously approved medicaid waiver
16 or SCHIP waiver.

17 ''(ii) A list identifying each provision
18 of title XIX or XXI, and each regulation
19 relating to either such title, for which com-
20 pliance is waived under the approved waiv-
21 er or amendment or for which costs that
22 would otherwise not be permitted under
23 the provision will be allowed.

24 ''(iii) The terms and conditions for
25 approval of the waiver or amendment.

1 "(v) The approval letter.
2 "(vi) The protocol for the waiver or
3 amendment.
4 "(vii) The evaluation design for the
5 waiver or amendment.
6 "(viii) The results of the evaluation of
7 the waiver or amendment.
8 Any item required to be posted under this sub-
9 paragraph that is not available within 3 days of
10 the approval of the waiver or amendment shall
11 be posted as soon as the item becomes avail-
12 able.
13 "(H) Each month the Secretary shall pub-
14 lish a notice in the Federal Register that identi-
15 fies any proposals for medicaid waivers, SCHIP
16 waivers, or amendments to a previously ap-
17 proved medicaid waiver or SCHIP waiver that
18 were approved, denied, or returned to the State
19 without action during the preceding month.
20 "(5) Any provision under title XIX or XXI, or
21 under any regulation in effect that relates to either
22 such title, that is not explicitly waived by the Sec-
23 retary when the medicaid waiver, SCHIP waiver, or
24 amendment is approved and identified in the list re-
25 quired under paragraph (4)(G)(ii), is not waived and

a State shall continue to comply with any such requirement.''.

(b) CLARIFICATION OF LIMITATIONS OF WAIVER AUTHORITY.—

(1) SECTION 1115 WAIVERS.—Paragraphs (1) and (2) of section 1115(a) of such Act (42 U.S.C. 1315(a)) are each amended by inserting ''and only to the extent that waiving such requirements is likely to assist in promoting the objectives of the title in which such section is located,'' after ''as the case may be,''.

(2) EPSDT.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(13) Notwithstanding section 1115(a), with respect to any waiver, experimental, pilot, or demonstration project that involves the use of funds made available under this title, or an amendment to such a project that has been approved as of the date of enactment of this paragraph, the Secretary may not waive compliance with the requirements of subsection (a)(43) (relating to early and periodic screening, diagnostic, and treatment services as described in section 1905(r)).''.

(3) USE OF SCHIP FUNDS.—

1 (A) IN GENERAL.—Section 2107 of the So-
2 cial Security Act (42 U.S.C. 1397gg) is amend-
3 ed by adding at the end the following:
4 "(f) LIMITATION OF WAIVER AUTHORITY.—Notwith-
5 standing subsection (e)(2)(A) and section 1115(a), the
6 Secretary may not approve a waiver, experimental, pilot,
7 or demonstration project, or an amendment to such a
8 project that has been approved as of the date of enactment
9 of this subsection, that would allow funds made available
10 under this title to be used to provide child health assist-
11 ance or other health benefits coverage to childless adults.
12 For purposes of the preceding sentence, a caretaker rel-
13 ative (as such term is defined for purposes of carrying out
14 section 1931) shall not be considered a childless adult.".
15 (B) CONFORMING AMENDMENT.—Section
16 2105(c)(1) of the Social Security Act (42
17 U.S.C. 1397ee(c)(1)) is amended by inserting
18 before the period the following: "and may not
19 include coverage of childless adults. For pur-
20 poses of the preceding sentence, a caretaker rel-
21 ative (as such term is defined for purposes of
22 carrying out section 1931) shall not be consid-
23 ered a childless adult.".

(c) RULE OF CONSTRUCTION.—Nothing in this section or the amendments made by this section shall be construed to—

(1) authorize the waiver of any provision of title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) that is not otherwise authorized to be waived under such titles or under title XI of such Act (42 U.S.C. 1301 et seq.) as of the date of enactment of this Act; or

(2) imply congressional approval of any waiver, experimental, pilot, or demonstration project affecting the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act that has been approved as of such date of enactment.

(d) EFFECTIVE DATE.—This section and the amendments made by this section take effect on the date of enactment of this Act and apply to proposals to conduct a waiver, experimental, pilot, or demonstration project affecting the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act, and to any proposals to amend such projects, that are approved or extended on or after such date of enactment.

TITLE IX—INDIAN HEALTH CARE FUNDING

SEC. 901. GUARANTEED ADEQUATE FUNDING FOR INDIAN HEALTH CARE.

Section 825 of the Indian Health Care Improvement Act (25 U.S.C. 1680*o*) is amended to read as follows:

"SEC. 825. FUNDING.

"(a) IN GENERAL.—Notwithstanding any other provision of law, not later than 30 days after the date of enactment of this section, on October 1, 2003, and on each October 1 thereafter, out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall transfer to the Secretary to carry out this title the amount determined under subsection (d).

"(b) USE AND AVAILABILITY.—

"(1) IN GENERAL.—An amount transferred under subsection (a)—

"(A) shall remain available until expended; and

"(B) shall be used to carry out any programs, functions, and activities relating to clinical services (as defined in paragraph (2)) of the Service and Service units.

"(2) CLINICAL SERVICES DEFINED.—For purposes of paragraph (1)(B), the term 'clinical serv-

ices' includes all programs of the Indian Health Service which are funded directly or under the authority of the Indian Self-Determination and Education Assistance Act, for the purposes of—

"(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

"(B) preventive health, including mammography and other cancer screening;

"(C) dental care;

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

"(G) accident prevention programs;

"(H) home health care;

"(I) community health representatives;

"(J) maintenance and repair; and

"(K) traditional health care practices and training of traditional health care practitioners.

"(c) RECEIPT AND ACCEPTANCE.—The Secretary shall be entitled to receive, shall accept, and shall use to carry out this title the funds transferred under subsection (a), without further appropriation.

"(d) AMOUNT.—The amount referred to in subsection (a) is—

"(1) for fiscal year 2004, the amount equal to 390 percent of the amount obligated by the Service during fiscal year 2002 for the purposes described in subsection (b)(2); and

"(2) for fiscal year 2005 and each fiscal year thereafter, the amount equal to the product obtained by multiplying—

"(A) the number of Indians served by the Service as of September 30 of the preceding the fiscal year; and

"(B) the per capita baseline amount, as determined under subsection (e).

"(e) PER CAPITA BASELINE AMOUNT.—

"(1) IN GENERAL.—For the purpose of subsection (d)(2)(B), the per capita baseline amount shall be equal to the sum of—

"(A) the quotient obtained by dividing—

"(i) the amount specified in subsection (d)(1); by

"(ii) the number of Indians served by the Service as of September 30, 2002; and

"(B) any applicable increase under paragraph (2).

"(2) INCREASE.—For each fiscal year, the Secretary shall provide a percentage increase (rounded to the nearest dollar) in the per capita baseline amount equal to the percentage by which—

"(A) the Consumer Price Index for all Urban Consumers published by the Department of Labor (relating to the United States city average for medical care and not seasonally adjusted) for the 1-year period ending on the June 30 of the fiscal year preceding the fiscal year for which the increase is made; exceeds

"(B) that Consumer Price Index for the 1-year period preceding the 1-year period described in subparagraph (A).".

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