

107TH CONGRESS
1ST SESSION

H. R. 2367

To amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide for accountability of health plans.

IN THE HOUSE OF REPRESENTATIVES

JUNE 28, 2001

Mr. SESSIONS (for himself and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committees on Energy and Commerce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code of 1986 to provide for accountability of health plans.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Patient Care Dispute Resolution Act of 2001”.

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

- Sec. 1. Short title and table of contents.
- Sec. 2. Consideration by plans of claims for benefits and reviews by plans of denials of such claims.
 - “Sec. 503A. Utilization review activities.
 - “Sec. 503B. Procedures for initial claims for benefits and prior authorization determinations.
 - “Sec. 503C. Internal appeals of claims denials.
 - “Sec. 503D. Independent external appeals procedures.
 - “Sec. 503E. Effect of Federal review standards for group health plans on availability of legal remedies under State law.
 - “Sec. 503F. Definitions relating to group health plans.
- Sec. 3. State flexibility in applying accountability rules to health insurance issuers.
- Sec. 4. Effective dates and related rules.
- Sec. 5. Regulations; coordination.
- Sec. 6. No benefit requirements.
- Sec. 7. Severability.

3 **SEC. 2. CONSIDERATION BY PLANS OF CLAIMS FOR BENE-**
4 **FITS AND REVIEWS BY PLANS OF DENIALS OF**
5 **SUCH CLAIMS.**

6 (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT
7 INCOME SECURITY ACT OF 1974.—

8 (1) IN GENERAL.—Part 5 of subtitle B of title
9 I of the Employee Retirement Income Security Act
10 of 1974 is amended by inserting after section 503
11 (29 U.S.C. 1133) the following new sections:

12 **“SEC. 503A. UTILIZATION REVIEW ACTIVITIES.**

13 **“(a) COMPLIANCE WITH REQUIREMENTS.—**

14 **“(1) IN GENERAL.—**A group health plan, and a
15 health insurance issuer that provides health insur-
16 ance coverage, shall conduct utilization review activi-
17 ties in connection with the provision of benefits

1 under such plan or coverage only in accordance with
2 a utilization review program that meets the require-
3 ments of this section and section 503B.

4 “(2) USE OF OUTSIDE AGENTS.—Nothing in
5 this section shall be construed as preventing a group
6 health plan or health insurance issuer from arrang-
7 ing through a contract or otherwise for persons or
8 entities to conduct utilization review activities on be-
9 half of the plan or issuer, so long as such activities
10 are conducted in accordance with a utilization review
11 program that meets the requirements of this section.

12 “(3) UTILIZATION REVIEW DEFINED.—For pur-
13 poses of this section, the terms ‘utilization review’
14 and ‘utilization review activities’ mean procedures
15 used to monitor or evaluate the use or coverage,
16 clinical necessity, appropriateness, efficacy, or effi-
17 ciency of health care services, procedures or settings,
18 and includes prospective review, concurrent review,
19 second opinions, case management, discharge plan-
20 ning, or retrospective review.

21 “(b) WRITTEN POLICIES AND CRITERIA.—

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

1 “(2) USE OF WRITTEN CRITERIA.—

2 “(A) IN GENERAL.—Such a program shall
3 utilize written clinical review criteria developed
4 with input from a range of appropriate actively
5 practicing physicians or dentists, as determined
6 by the plan, pursuant to the program. Such cri-
7 teria shall include written clinical review criteria
8 that are based on valid clinical evidence where
9 available and that are directed specifically at
10 meeting the needs of at-risk populations and
11 covered individuals with chronic conditions or
12 severe illnesses, including gender-specific cri-
13 teria and pediatric-specific criteria where avail-
14 able and appropriate.

15 “(B) CONTINUING USE OF STANDARDS IN
16 RETROSPECTIVE REVIEW.—If a health care
17 service has been specifically pre-authorized or
18 approved for a participant or beneficiary under
19 such a program, the program shall not, pursu-
20 ant to retrospective review, revise or modify the
21 specific standards, criteria, or procedures used
22 for the utilization review for procedures, treat-
23 ment, and services delivered to the participant
24 or beneficiary during the same course of treat-
25 ment.

1 “(C) REVIEW OF SAMPLE OF CLAIMS DE-
2 NIALS.—Such a program shall provide for an
3 evaluation of the clinical appropriateness of at
4 least a sample of denials of claims for benefits.

5 “(c) CONDUCT OF PROGRAM ACTIVITIES.—

6 “(1) ADMINISTRATION BY PHYSICIANS OR DEN-
7 TISTS.—A utilization review program shall be ad-
8 ministered by qualified physicians or dentists who
9 shall oversee review decisions.

10 “(2) USE OF QUALIFIED, INDEPENDENT PER-
11 SONNEL.—

12 “(A) IN GENERAL.—A utilization review
13 program shall provide for the conduct of utiliza-
14 tion review activities only through personnel
15 who are qualified and have received appropriate
16 training in the conduct of such activities under
17 the program.

18 “(B) PROHIBITION OF CONTINGENT COM-
19 PENSATION ARRANGEMENTS.—Such a program
20 shall not, with respect to utilization review ac-
21 tivities, permit or provide compensation or any-
22 thing of value to its employees, agents, or con-
23 tractors in a manner that encourages denials of
24 claims for benefits.

1 “(C) PROHIBITION OF CONFLICTS.—Such
2 a program shall not permit a health care pro-
3 fessional who is providing health care services
4 to an individual to perform utilization review
5 activities in connection with the health care
6 services being provided to the individual.

7 “(3) ACCESSIBILITY OF REVIEW.—Such a pro-
8 gram shall provide that appropriate personnel per-
9 forming utilization review activities under the pro-
10 gram, including the utilization review administrator,
11 are reasonably accessible by toll-free telephone dur-
12 ing normal business hours to discuss patient care
13 and allow response to telephone requests, and that
14 appropriate provision is made to receive and respond
15 promptly to calls received during other hours.

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

1 **“SEC. 503B. PROCEDURES FOR INITIAL CLAIMS FOR BENE-**
2 **FITS AND PRIOR AUTHORIZATION DETER-**
3 **MINATIONS.**

4 “(a) PROCEDURES OF INITIAL CLAIMS FOR BENE-
5 FITS.—

6 “(1) IN GENERAL.—A group health plan, or
7 health insurance issuer offering health insurance
8 coverage in connection with a group health plan,
9 shall—

10 “(A) make a determination on an initial
11 claim for benefits by a participant or bene-
12 ficiary (or authorized representative) regarding
13 payment or coverage for items or services under
14 the terms and conditions of the plan or cov-
15 erage involved, including any cost-sharing
16 amount that the participant or beneficiary is re-
17 quired to pay with respect to such claim for
18 benefits; and

19 “(B) notify a participant or beneficiary (or
20 authorized representative) and the treating
21 health care professional involved regarding a
22 determination on an initial claim for benefits
23 made under the terms and conditions of the
24 plan or coverage, including any cost-sharing
25 amounts that the participant or beneficiary may
26 be required to make with respect to such claim

1 for benefits, and of the right of the participant
2 or beneficiary to an internal appeal under sec-
3 tion 503C.

4 “(2) ACCESS TO INFORMATION.—With respect
5 to an initial claim for benefits, the participant or
6 beneficiary (or authorized representative) and the
7 treating health care professional (if any) shall pro-
8 vide the plan or issuer with access to information re-
9 quested by the plan or issuer that is necessary to
10 make a determination relating to the claim. Such ac-
11 cess shall be provided not later than 5 days after the
12 date on which the request for information is re-
13 ceived, or, in a case described in subparagraph (B)
14 or (C) of subsection (b)(1), by such earlier time as
15 may be necessary to comply with the applicable
16 timeline under such subparagraph.

17 “(3) ORAL REQUESTS.—In the case of a claim
18 for benefits involving an expedited or concurrent de-
19 termination, a participant or beneficiary (or author-
20 ized representative) may make an initial claim for
21 benefits orally, but a group health plan, or health in-
22 surance issuer offering health insurance coverage,
23 may require that the participant or beneficiary (or
24 authorized representative) provide written confirma-
25 tion of such request in a timely manner on a form

1 provided by the plan or issuer. In the case of such
2 an oral request for benefits, the making of the re-
3 quest (and the timing of such request) shall be
4 treated as the making at that time of a claim for
5 such benefits without regard to whether and when a
6 written confirmation of such request is made.

7 “(b) TIMELINE FOR MAKING DETERMINATIONS.—

8 “(1) PRIOR AUTHORIZATION DETERMINA-
9 TION.—

10 “(A) IN GENERAL.—A group health plan,
11 or health insurance issuer offering health insur-
12 ance coverage in connection with a group health
13 plan, shall make a prior authorization deter-
14 mination on a claim for benefits (whether oral
15 or written) as soon as possible in accordance
16 with the medical exigencies of the case but in
17 no case later than 14 days from the date on
18 which the plan or issuer receives information
19 that is reasonably necessary to enable the plan
20 or issuer to make a determination on the re-
21 quest for prior authorization and in no case
22 later than 28 days after the date of the claim
23 for benefits is received.

24 “(B) EXPEDITED DETERMINATION.—Not-
25 withstanding subparagraph (A), a group health

1 plan, or health insurance issuer offering health
2 insurance coverage in connection with a group
3 health plan, shall expedite a prior authorization
4 determination on a claim for benefits described
5 in such subparagraph when a request for such
6 an expedited determination is made by a partic-
7 ipant or beneficiary (or authorized representa-
8 tive) at any time during the process for making
9 a determination and a health care professional
10 certifies, with the request, that a determination
11 under the procedures described in subparagraph
12 (A) would seriously jeopardize the life or health
13 of the participant or beneficiary or the ability
14 of the participant or beneficiary to maintain or
15 regain maximum function. Such determination
16 shall be made as soon as possible based on the
17 medical exigencies of the case involved and in
18 no case later than 72 hours after the time the
19 request is received by the plan or issuer under
20 this subparagraph.

21 “(C) ONGOING CARE.—

22 “(i) CONCURRENT REVIEW.—

23 “(I) IN GENERAL.—Subject to
24 clause (ii), in the case of a concurrent
25 review of ongoing care (including hos-

1 pitalization), which results in a termi-
2 nation or reduction of such care, the
3 plan or issuer must provide by tele-
4 phone and in printed form notice of
5 the concurrent review determination
6 to the individual or the individual's
7 designee and the individual's health
8 care provider as soon as possible in
9 accordance with the medical exigen-
10 cies of the case, with sufficient time
11 prior to the termination or reduction
12 to allow for an appeal under section
13 503C(b)(3) to be completed before the
14 termination or reduction takes effect.

15 “(II) CONTENTS OF NOTICE.—

16 Such notice shall include, with respect
17 to ongoing health care items and serv-
18 ices, the number of ongoing services
19 approved, the new total of approved
20 services, the date of onset of services,
21 and the next review date, if any, as
22 well as a statement of the individual's
23 rights to further appeal.

24 “(ii) RULE OF CONSTRUCTION.—

25 Clause (i) shall not be construed as requir-

1 ing plans or issuers to provide coverage of
2 care that would exceed the coverage limita-
3 tions for such care.

4 “(2) RETROSPECTIVE DETERMINATION.—A
5 group health plan, or health insurance issuer offer-
6 ing health insurance coverage in connection with a
7 group health plan, shall make a retrospective deter-
8 mination on a claim for benefits as soon as possible
9 in accordance with the medical exigencies of the case
10 but not later than 30 days after the date on which
11 the plan or issuer receives information that is rea-
12 sonably necessary to enable the plan or issuer to
13 make a determination on the claim, or, if earlier, 60
14 days after the date of receipt of the claim for bene-
15 fits.

16 “(c) NOTICE OF A DENIAL OF A CLAIM FOR BENE-
17 FITS.—Written notice of a denial made under an initial
18 claim for benefits shall be issued to the participant or ben-
19 eficiary (or authorized representative) and the treating
20 health care professional as soon as possible in accordance
21 with the medical exigencies of the case and in no case later
22 than 2 days after the date of the determination (or, in
23 the case described in subparagraph (B) or (C) of sub-
24 section (b)(1), within the 72-hour or applicable period re-
25 ferred to in such subparagraph).

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

7 “(1) the specific reasons for the determination
8 (including a summary of the clinical or scientific evi-
9 dence used in making the determination);

10 “(2) the procedures for obtaining additional in-
11 formation concerning the determination; and

12 “(3) notification of the right to appeal the de-
13 termination and instructions on how to initiate an
14 appeal in accordance with section 503C.

15 **“SEC. 503C. INTERNAL APPEALS OF CLAIMS DENIALS.**

16 “(a) RIGHT TO INTERNAL APPEAL.—

17 “(1) IN GENERAL.—A participant or beneficiary
18 of a group health plan (or authorized representative)
19 may appeal any denial of a claim for benefits under
20 section 503B under the procedures described in this
21 section.

22 “(2) TIME FOR APPEAL.—

23 “(A) IN GENERAL.—A group health plan,
24 or health insurance issuer offering health insur-
25 ance coverage in connection with a group health

1 plan, shall ensure that a participant or bene-
2 ficiary (or authorized representative) has a pe-
3 riod of not less than 180 days beginning on the
4 date of a denial of a claim for benefits under
5 section 503B in which to appeal such denial
6 under this section.

7 “(B) DATE OF DENIAL.—For purposes of
8 subparagraph (A), the date of the denial shall
9 be deemed to be the date as of which the partic-
10 ipant or beneficiary knew of the denial of the
11 claim for benefits.

12 “(3) FAILURE TO ACT.—The failure of a plan
13 or issuer to issue a determination on a claim for
14 benefits under section 503B within the applicable
15 timeline established for such a determination under
16 such section is a denial of a claim for benefits for
17 purposes this section and section 503D as of the
18 date of the applicable deadline.

19 “(4) PLAN WAIVER OF INTERNAL REVIEW.—A
20 group health plan, or health insurance issuer offer-
21 ing health insurance coverage in connection with a
22 group health plan, may waive the internal review
23 process under this section. In such case the plan or
24 issuer shall provide notice to the participant or bene-
25 ficiary (or authorized representative) involved, the

1 participant or beneficiary (or authorized representa-
2 tive) involved shall be relieved of any obligation to
3 complete the internal review involved, and may, at
4 the option of such participant, beneficiary, or rep-
5 resentative proceed directly to seek further appeal
6 through external review under section 503D or oth-
7 erwise.

8 “(b) TIMELINES FOR MAKING DETERMINATIONS.—

9 “(1) ORAL REQUESTS.—In the case of an ap-
10 peal of a denial of a claim for benefits under this
11 section that involves an expedited or concurrent de-
12 termination, a participant or beneficiary (or author-
13 ized representative) may request such appeal orally.
14 A group health plan, or health insurance issuer of-
15 fering health insurance coverage in connection with
16 a group health plan, may require that the partici-
17 pant or beneficiary (or authorized representative)
18 provide written confirmation of such request in a
19 timely manner on a form provided by the plan or
20 issuer. In the case of such an oral request for an ap-
21 peal of a denial, the making of the request (and the
22 timing of such request) shall be treated as the mak-
23 ing at that time of a request for an appeal without
24 regard to whether and when a written confirmation
25 of such request is made.

1 “(2) ACCESS TO INFORMATION.—With respect
2 to an appeal of a denial of a claim for benefits, the
3 participant or beneficiary (or authorized representa-
4 tive) and the treating health care professional (if
5 any) shall provide the plan or issuer with access to
6 information requested by the plan or issuer that is
7 necessary to make a determination relating to the
8 appeal. Such access shall be provided not later than
9 5 days after the date on which the request for infor-
10 mation is received, or, in a case described in sub-
11 paragraph (B) or (C) of paragraph (3), by such ear-
12 lier time as may be necessary to comply with the ap-
13 plicable timeline under such subparagraph.

14 “(3) PRIOR AUTHORIZATION DETERMINA-
15 TIONS.—

16 “(A) IN GENERAL.—A group health plan,
17 or health insurance issuer offering health insur-
18 ance coverage in connection with a group health
19 plan, shall make a determination on an appeal
20 of a denial of a claim for benefits under this
21 subsection as soon as possible in accordance
22 with the medical exigencies of the case but in
23 no case later than 14 days from the date on
24 which the plan or issuer receives information
25 that is reasonably necessary to enable the plan

1 or issuer to make a determination on the appeal
2 and in no case later than 28 days after the date
3 the request for the appeal is received.

4 “(B) EXPEDITED DETERMINATION.—Not-
5 withstanding subparagraph (A), a group health
6 plan, or health insurance issuer offering health
7 insurance coverage in connection with a group
8 health plan, shall expedite a prior authorization
9 determination on an appeal of a denial of a
10 claim for benefits described in subparagraph
11 (A), when a request for such an expedited de-
12 termination is made by a participant or bene-
13 ficiary (or authorized representative) at any
14 time during the process for making a deter-
15 mination and a health care professional cer-
16 tifies, with the request, that a determination
17 under the procedures described in subparagraph
18 (A) would seriously jeopardize the life or health
19 of the participant or beneficiary or the ability of
20 the participant or beneficiary to maintain or re-
21 gain maximum function. Such determination
22 shall be made as soon as possible based on the
23 medical exigencies of the case involved and in
24 no case later than 72 hours after the time the

1 request for such appeal is received by the plan
2 or issuer under this subparagraph.

3 “(C) ONGOING CARE DETERMINATIONS.—

4 “(i) IN GENERAL.—Subject to clause
5 (ii), in the case of a concurrent review de-
6 termination described in section
7 503B(b)(1)(C)(i)(I), which results in a ter-
8 mination or reduction of such care, the
9 plan or issuer must provide notice of the
10 determination on the appeal under this
11 section by telephone and in printed form to
12 the individual or the individual’s designee
13 and the individual’s health care provider as
14 soon as possible in accordance with the
15 medical exigencies of the case, with suffi-
16 cient time prior to the termination or re-
17 duction to allow for an external appeal
18 under section 503D to be completed before
19 the termination or reduction takes effect.

20 “(ii) RULE OF CONSTRUCTION.—

21 Clause (i) shall not be construed as requir-
22 ing plans or issuers to provide coverage of
23 care that would exceed the coverage limita-
24 tions for such care.

1 “(4) RETROSPECTIVE DETERMINATION.—A
2 group health plan, or health insurance issuer offer-
3 ing health insurance coverage in connection with a
4 group health plan, shall make a retrospective deter-
5 mination on an appeal of a claim for benefits in no
6 case later than 30 days after the date on which the
7 plan or issuer receives necessary information that is
8 reasonably necessary to enable the plan or issuer to
9 make a determination on the appeal and in no case
10 later than 60 days after the date the request for the
11 appeal is received.

12 “(c) CONDUCT OF REVIEW.—

13 “(1) IN GENERAL.—A review of a denial of a
14 claim for benefits under this section shall be con-
15 ducted by an individual with appropriate expertise
16 who was not involved in the initial determination.

17 “(2) APPROPRIATE REVIEW OF MEDICAL DECI-
18 SIONS.—A review of an appeal of a denial of a claim
19 for benefits that is based on a lack of medical neces-
20 sity and appropriateness, or based on an experi-
21 mental or investigational treatment, or requires an
22 evaluation of medical facts, shall be made by a phy-
23 sician (allopathic or osteopathic) or dentist with ap-
24 propriate expertise (including, in the case of a child,

1 appropriate pediatric expertise) who was not in-
2 volved in the initial determination.

3 “(d) NOTICE OF DETERMINATION.—

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

15 “(2) FINAL DETERMINATION.—The decision by
16 a plan or issuer under this section shall be treated
17 as the final determination of the plan or issuer on
18 a denial of a claim for benefits. The failure of a plan
19 or issuer to issue a determination on an appeal of
20 a denial of a claim for benefits under this section
21 within the applicable timeline established for such a
22 determination shall be treated as a final determina-
23 tion on an appeal of a denial of a claim for benefits
24 for purposes of proceeding to external review under
25 section 503D.

1 “(3) REQUIREMENTS OF NOTICE.—With re-
2 spect to a determination made under this section,
3 the notice described in paragraph (1) shall be pro-
4 vided in printed form and written in a manner cal-
5 culated to be understood by the average participant
6 or beneficiary and shall include—

7 “(A) the specific reasons for the deter-
8 mination (including a summary of the clinical
9 or scientific evidence used in making the deter-
10 mination);

11 “(B) the procedures for obtaining addi-
12 tional information concerning the determina-
13 tion; and

14 “(C) notification of the right to an inde-
15 pendent external review under section 503D
16 and instructions on how to initiate such a re-
17 view.

18 **“SEC. 503D. INDEPENDENT EXTERNAL APPEALS PROCE-**
19 **DURES.**

20 “(a) RIGHT TO EXTERNAL APPEAL.—A group health
21 plan, and a health insurance issuer offering health insur-
22 ance coverage in connection with a group health plan, shall
23 provide in accordance with this section participants and
24 beneficiaries (or authorized representatives) with access to
25 an independent external review for any denial of a claim

1 for benefits in any case in which the amount involved ex-
2 ceeds \$100.

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

5 “(1) TIME TO FILE.—A request for an inde-
6 pendent external review under this section shall be
7 filed with the plan or issuer not later than 180 days
8 after the date on which the participant or bene-
9 ficiary receives notice of the denial under section
10 503C(d) or notice of waiver of internal review under
11 section 503C(a)(4) or the date on which the plan or
12 issuer has failed to make a timely decision under
13 section 503C(d)(2).

14 “(2) FILING OF REQUEST.—

15 “(A) IN GENERAL.—Subject to the suc-
16 ceeding provisions of this subsection, a group
17 health plan, and a health insurance issuer offer-
18 ing health insurance coverage, may—

19 “(i) except as provided in subpara-
20 graph (B)(i), require that a request for re-
21 view be in writing;

22 “(ii) limit the filing of such a request
23 to the participant or beneficiary involved
24 (or an authorized representative);

1 “(iii) except if waived by the plan or
2 issuer under section 503C(a)(4), condition
3 access to an independent external review
4 under this section upon a final determina-
5 tion of a denial of a claim for benefits
6 under the internal review procedure under
7 section 503C;

8 “(iv) except as provided in subpara-
9 graph (B)(ii), require payment of a filing
10 fee to the plan or issuer of a sum that does
11 not exceed \$25; and

12 “(v) require that a request for review
13 include the consent of the participant or
14 beneficiary (or authorized representative)
15 for the release of medical information or
16 records of the participant or beneficiary to
17 the qualified external review entity for the
18 sole purpose of conducting external review
19 activities.

20 “(B) REQUIREMENTS AND EXCEPTION RE-
21 LATING TO GENERAL RULE.—

22 “(i) ORAL REQUESTS PERMITTED IN
23 EXPEDITED OR CONCURRENT CASES.—In
24 the case of an expedited or concurrent ex-
25 ternal review as provided for under sub-

1 section (e), the request may be made oral-
2 ly. A group health plan, or health insur-
3 ance issuer offering health insurance cov-
4 erage, may require that the participant or
5 beneficiary (or authorized representative)
6 provide written confirmation of such re-
7 quest in a timely manner on a form pro-
8 vided by the plan or issuer. Such written
9 confirmation shall be treated as a consent
10 for purposes of subparagraph (A)(v). In
11 the case of such an oral request for such
12 a review, the making of the request (and
13 the timing of such request) shall be treated
14 as the making at that time of a request for
15 such an external review without regard to
16 whether and when a written confirmation
17 of such request is made.

18 “(ii) EXCEPTION TO FILING FEE RE-
19 QUIREMENT.—

20 “(I) INDIGENCY.—Payment of a
21 filing fee shall not be required under
22 subparagraph (A)(iv) where there is a
23 certification (in a form and manner
24 specified in guidelines established by
25 the Secretary) that the participant or

1 beneficiary is indigent (as defined in
2 such guidelines).

3 “(II) FEE NOT REQUIRED.—Pay-
4 ment of a filing fee shall not be re-
5 quired under subparagraph (A)(iv) if
6 the plan or issuer waives the internal
7 appeals process under section
8 503C(a)(4).

9 “(III) REFUNDING OF FEE.—
10 The filing fee paid under subpara-
11 graph (A)(iv) shall be refunded if the
12 determination under the independent
13 external review is to reverse the denial
14 which is the subject of the review.

15 “(IV) COLLECTION OF FILING
16 FEE.—The failure to pay such a filing
17 fee shall not prevent the consideration
18 of a request for review but, subject to
19 the preceding provisions of this clause,
20 shall constitute a legal liability to pay.

21 “(c) REFERRAL TO QUALIFIED EXTERNAL REVIEW
22 ENTITY UPON REQUEST.—

23 “(1) IN GENERAL.—Upon the filing of a re-
24 quest for independent external review with the group
25 health plan, or health insurance issuer offering

1 health insurance coverage, the plan or issuer shall
2 immediately refer such request, and forward the
3 plan or issuer’s initial decision (including the infor-
4 mation described in section 503C(d)(3)(A)), to a
5 qualified external review entity selected in accord-
6 ance with this section.

7 “(2) ACCESS TO PLAN OR ISSUER AND HEALTH
8 PROFESSIONAL INFORMATION.—With respect to an
9 independent external review conducted under this
10 section, the participant or beneficiary (or authorized
11 representative), the plan or issuer, and the treating
12 health care professional (if any) shall provide the ex-
13 ternal review entity with information that is nec-
14 essary to conduct a review under this section, as de-
15 termined and requested by the entity. Such informa-
16 tion shall be provided not later than 5 days after the
17 date on which the request for information is re-
18 ceived, or, in a case described in clause (ii) or (iii)
19 of subsection (e)(1)(A), by such earlier time as may
20 be necessary to comply with the applicable timeline
21 under such clause.

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

24 “(A) IN GENERAL.—With respect to a re-
25 quest referred to a qualified external review en-

1 tity under paragraph (1) relating to a denial of
2 a claim for benefits, the entity shall refer such
3 request for the conduct of an independent med-
4 ical review unless the entity determines that—

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

8 “(ii) the denial of the claim for bene-
9 fits does not involve a medically reviewable
10 decision under subsection (d)(2);

11 “(iii) the denial of the claim for bene-
12 fits relates to a decision regarding whether
13 an individual is a participant or beneficiary
14 who is enrolled under the terms and condi-
15 tions of the plan or coverage (including the
16 applicability of any waiting period under
17 the plan or coverage); or

18 “(iv) the denial of the claim for bene-
19 fits is a decision as to the application of
20 cost-sharing requirements or the applica-
21 tion of a specific exclusion or express limi-
22 tation on the amount, duration, or scope of
23 coverage of items or services under the
24 terms and conditions of the plan or cov-

1 erage unless the decision is a denial de-
2 scribed in subsection (d)(2).

3 Upon making a determination that any of
4 clauses (i) through (iv) applies with respect to
5 the request, the entity shall determine that the
6 denial of a claim for benefits involved is not eli-
7 gible for independent medical review under sub-
8 section (d), and shall provide notice in accord-
9 ance with subparagraph (C).

10 “(B) PROCESS FOR MAKING DETERMINA-
11 TIONS.—

12 “(i) NO DEFERENCE TO PRIOR DE-
13 TERMINATIONS.—In making determina-
14 tions under subparagraph (A), there shall
15 be no deference given to determinations
16 made by the plan or issuer or the rec-
17 ommendation of a treating health care pro-
18 fessional (if any).

19 “(ii) USE OF APPROPRIATE PER-
20 SONNEL.—A qualified external review enti-
21 ty shall use appropriately qualified per-
22 sonnel to make determinations under this
23 section.

24 “(C) NOTICES AND GENERAL TIMELINES
25 FOR DETERMINATION.—

1 “(i) NOTICE IN CASE OF DENIAL OF
2 REFERRAL.—If the entity under this para-
3 graph does not make a referral for the
4 conduct of an independent medical review,
5 the entity shall provide notice to the plan
6 or issuer, the participant or beneficiary (or
7 authorized representative) filing the re-
8 quest, and the treating health care profes-
9 sional (if any) that the denial is not sub-
10 ject to independent medical review. Such
11 notice—

12 “(I) shall be written (and, in ad-
13 dition, may be provided orally) in a
14 manner calculated to be understood
15 by an average participant or bene-
16 ficiary;

17 “(II) shall include the reasons for
18 the determination;

19 “(III) include any relevant terms
20 and conditions of the plan or cov-
21 erage; and

22 “(IV) include a description of
23 any further recourse available to the
24 individual.

1 “(ii) GENERAL TIMELINE FOR DETER-
2 MINATIONS.—Upon receipt of information
3 under paragraph (2), the qualified external
4 review entity, and if required the inde-
5 pendent medical review panel conducting
6 independent medical review under sub-
7 section (d), shall make a determination
8 within the overall timeline that is applica-
9 ble to the case under review as described
10 in subsection (e), except that if the entity
11 determines that a referral to an inde-
12 pendent medical review panel is not re-
13 quired, the entity shall provide notice of
14 such determination to the participant or
15 beneficiary (or authorized representative)
16 within such timeline and within 2 days of
17 the date of such determination.

18 “(d) INDEPENDENT MEDICAL REVIEW.—

19 “(1) IN GENERAL.—If a qualified external re-
20 view entity determines under subsection (c) that a
21 denial of a claim for benefits is eligible for inde-
22 pendent medical review, the entity shall refer the de-
23 nial involved to an independent medical review panel
24 comprised of 3 members meeting the requirements

1 of subsection (g) for the conduct of an independent
2 medical review under this subsection.

3 “(2) MEDICALLY REVIEWABLE DECISIONS.—A
4 denial of a claim for benefits is eligible for inde-
5 pendent medical review if the benefit for the item or
6 service for which the claim is made would be a cov-
7 ered benefit under the terms and conditions of the
8 plan or coverage but for one (or more) of the fol-
9 lowing determinations:

10 “(A) DENIALS BASED ON MEDICAL NECES-
11 SITY AND APPROPRIATENESS.—A determination
12 that the item or service is not covered because
13 it is not medically necessary and appropriate or
14 based on the application of substantially equiva-
15 lent terms.

16 “(B) DENIALS BASED ON EXPERIMENTAL
17 OR INVESTIGATIONAL TREATMENT.—A deter-
18 mination that the item or service is not covered
19 because it is experimental or investigational or
20 based on the application of substantially equiva-
21 lent terms.

22 “(C) DENIALS OTHERWISE BASED ON AN
23 EVALUATION OF MEDICAL FACTS.—A deter-
24 mination that the item or service or condition
25 is not covered based on grounds that require an

1 evaluation of the medical facts by a health care
2 professional in the specific case involved to de-
3 termine the coverage and extent of coverage of
4 the item or service or condition.

5 “(3) INDEPENDENT MEDICAL REVIEW DETER-
6 MINATION.—

7 “(A) IN GENERAL.—An independent med-
8 ical review panel under this section shall make
9 a new independent determination with respect
10 to whether or not the denial of a claim for a
11 benefit that is the subject of the review should
12 be upheld, reversed, or modified.

13 “(B) STANDARD FOR DETERMINATION.—
14 The independent medical review panel’s deter-
15 mination relating to the medical necessity and
16 appropriateness, or the experimental or inves-
17 tigation nature, or the evaluation of the medical
18 facts of the item, service, or condition shall be
19 based on the medical condition of the partici-
20 pant or beneficiary (including the medical
21 records of the participant or beneficiary) and
22 valid, relevant scientific evidence and clinical
23 evidence, including peer-reviewed medical lit-
24 erature or findings and including expert opin-
25 ion.

1 “(C) NO COVERAGE FOR EXCLUDED BENE-
2 FITS.—Nothing in this subsection shall be con-
3 strued to permit an independent medical review
4 panel 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 or
10 coverage document, except to the extent that
11 the application or interpretation of the exclu-
12 sion or limitation involves a determination de-
13 scribed in paragraph (2).

14 “(D) EVIDENCE AND INFORMATION TO BE
15 USED IN MEDICAL REVIEWS.—In making a de-
16 termination under this subsection, the inde-
17 pendent medical review panel shall also consider
18 appropriate and available evidence and informa-
19 tion, including the following:

20 “(i) The determination made by the
21 plan or issuer with respect to the claim
22 upon internal review and the evidence,
23 guidelines, or rationale used by the plan or
24 issuer in reaching such determination.

1 “(ii) The recommendation of the
2 treating health care professional and the
3 evidence, guidelines, and rationale used by
4 the treating health care professional in
5 reaching such recommendation.

6 “(iii) Additional relevant evidence or
7 information obtained by the independent
8 medical review panel or submitted by the
9 plan, issuer, participant or beneficiary (or
10 an authorized representative), or treating
11 health care professional.

12 “(iv) The plan or coverage document.

13 “(E) INDEPENDENT DETERMINATION.—In
14 making determinations under this subtitle, a
15 qualified external review entity and an inde-
16 pendent medical review panel shall—

17 “(i) consider the claim under review
18 without deference to the determinations
19 made by the plan or issuer or the rec-
20 ommendation of the treating health care
21 professional (if any); and

22 “(ii) consider, but not be bound by
23 the definition used by the plan or issuer of
24 ‘medically necessary and appropriate’, or
25 ‘experimental or investigational’, or other

1 substantially equivalent terms that are
2 used by the plan or issuer to describe med-
3 ical necessity and appropriateness or ex-
4 perimental or investigational nature of the
5 treatment.

6 “(F) DETERMINATION OF INDEPENDENT
7 MEDICAL REVIEW PANEL.—An independent
8 medical review panel shall, in accordance with
9 the deadlines described in subsection (e), pre-
10 pare a written determination to uphold or re-
11 verse the denial under review. Such written de-
12 termination shall include—

13 “(i) the determination of the panel;

14 “(ii) the specific reasons of the panel
15 for such determination, including a sum-
16 mary of the clinical or scientific evidence
17 used in making the determination; and

18 “(iii) with respect to a determination
19 to reverse the denial under review, a time-
20 frame within which the plan or issuer must
21 comply with such determination.

22 “(e) TIMELINES AND NOTIFICATIONS.—

23 “(1) TIMELINES FOR INDEPENDENT MEDICAL
24 REVIEW.—

1 “(A) PRIOR AUTHORIZATION DETERMINA-
2 TION.—

3 “(i) IN GENERAL.—The independent
4 medical review panel shall make a deter-
5 mination under subsection (d) on a denial
6 of a claim for benefits in accordance with
7 the medical exigencies of the case but not
8 later than 14 days after the date of receipt
9 of information under subsection (c)(2) if
10 the review involves a prior authorization of
11 items or services and in no case later than
12 21 days after the date the request for ex-
13 ternal review is received.

14 “(ii) EXPEDITED DETERMINATION.—
15 Notwithstanding clause (i) and subject to
16 clause (iii), the independent medical review
17 panel shall make an expedited determina-
18 tion under subsection (d) on a denial of a
19 claim for benefits described in clause (i),
20 when a request for such an expedited de-
21 termination is made by a participant or
22 beneficiary (or authorized representative)
23 at any time during the process for making
24 a determination, and a health care profes-
25 sional certifies, with the request, that a de-

1 termination under the timeline described in
2 clause (i) would seriously jeopardize the
3 life or health of the participant or bene-
4 ficiary or the ability of the participant or
5 beneficiary to maintain or regain maximum
6 function. Such determination shall be
7 made as soon as possible based on the
8 medical exigencies of the case involved and
9 in no case later than 72 hours after the
10 time the request for external review is re-
11 ceived by the qualified external review enti-
12 ty.

13 “(iii) ONGOING CARE DETERMINA-
14 TION.—Notwithstanding clause (i), in the
15 case of a review described in such sub-
16 clause that involves a termination or reduc-
17 tion of care, the notice of the determina-
18 tion shall be completed not later than 24
19 hours after the time the request for exter-
20 nal review is received by the qualified ex-
21 ternal review entity and before the end of
22 the approved period of care.

23 “(B) RETROSPECTIVE DETERMINATION.—
24 The independent medical review panel shall
25 complete a review under subsection (d) in the

1 case of a retrospective determination concerning
2 a denial of a claim for benefits not later than
3 30 days after the date of receipt of information
4 under subsection (e)(2) and in no case later
5 than 60 days after the date the request for ex-
6 ternal review is received by the qualified exter-
7 nal review entity.

8 “(2) NOTIFICATION OF DETERMINATION.—The
9 external review entity shall ensure that the plan or
10 issuer, the participant or beneficiary (or authorized
11 representative) and the treating health care profes-
12 sional (if any) receives a copy of the written deter-
13 mination of the independent medical review panel
14 prepared under subsection (d)(3)(F). Nothing in this
15 paragraph shall be construed as preventing an entity
16 or panel from providing an initial oral notice of the
17 determination.

18 “(3) FORM OF NOTICES.—Determinations and
19 notices under this subsection shall be written in a
20 manner calculated to be understood by an average
21 participant.

22 “(f) COMPLIANCE.—

23 “(1) FAILURE TO COMPLY WITH TIMELINES
24 FOR REVIEW.—In any case in which a decision by a
25 medical review panel is not made within the applica-

1 ble timeline under subsection (e)(1), the Secretary
2 may assess a civil penalty against the plan or issuer
3 of up to \$1,000 a day from the date on which such
4 action is required under such timeline and ending on
5 the date on which such action is taken, except that,
6 in any case in which such action is not taken within
7 7 business days following the date on which such ac-
8 tion is required, the Secretary may assess, in lieu of
9 such civil penalty, a civil penalty not to exceed
10 \$500,000.

11 “(2) APPLICATION OF DETERMINATIONS.—

12 “(A) EXTERNAL REVIEW DETERMINATIONS
13 BINDING ON PLAN.—The determinations of an
14 external review entity and an independent med-
15 ical review panel under this section shall be
16 binding upon the plan or issuer involved.

17 “(B) COMPLIANCE WITH DETERMINA-
18 TION.—If the determination of an independent
19 medical review panel is to reverse the denial,
20 the plan or issuer, upon the receipt of such de-
21 termination, shall authorize coverage to comply
22 with the panel’s determination in accordance
23 with the timeframe established by the panel.

24 “(C) FAILURE TO COMPLY.—If a plan or
25 issuer fails to comply with the timeframe estab-

1 lished under subparagraph (B) with respect to
2 a participant or beneficiary, the Secretary may
3 assess a civil penalty against the plan or issuer
4 of up to \$3,000,000.

5 “(3) PROTECTION OF LEGAL RIGHTS.—Nothing
6 in this subsection or subtitle shall be construed as
7 altering or eliminating any cause of action or legal
8 rights or remedies of participants, beneficiaries, and
9 others under State or Federal law (including sec-
10 tions 502 and 503), including the right to file judi-
11 cial actions to enforce rights.

12 “(4) TREATMENT OF AMOUNTS COLLECTED AS
13 ASSESSMENTS.—Amounts collected pursuant to any
14 assessment under this subsection shall be credited to
15 a special fund established in the Treasury of the
16 United States for assessments under this subsection.
17 The amounts so credited, to the extent and in the
18 amounts provided in advance in appropriations Acts,
19 shall be available to defray expenses incurred in car-
20 rying out this section. The amounts so credited shall
21 not be scored as receipts under section 252 of the
22 Balanced Budget and Emergency Deficit Control
23 Act of 1985, and the amounts so credited shall be
24 credited as a discretionary offset to discretionary
25 spending to the extent that the amounts so credited

1 are made available for expenditure in appropriations
2 Acts.

3 “(5) EXEMPTION FROM LIABILITY FOR COMPLI-
4 ANCE WITH DECISIONS OF INDEPENDENT MEDICAL
5 REVIEW PANEL.—A health care provider shall not be
6 liable under any provision of law for any act or fail-
7 ure to act by such provider which is in compliance
8 with any requirement imposed by the decision of an
9 independent medical review panel under this section.

10 “(g) QUALIFICATIONS OF MEMBERS OF INDE-
11 PENDENT MEDICAL REVIEW PANELS.—

12 “(1) IN GENERAL.—In referring a denial to an
13 independent medical review panel to conduct inde-
14 pendent medical review under subsection (c), the
15 qualified external review entity shall ensure that—

16 “(A) each member of the panel meets the
17 qualifications described in paragraphs (2) and
18 (3);

19 “(B) with respect to each review the re-
20 quirements described in paragraphs (4) and (5)
21 for the panel are met; and

22 “(C) compensation provided by the entity
23 to each member of the panel is consistent with
24 paragraph (6).

1 “(2) LICENSURE AND EXPERTISE.—Each mem-
2 ber of the independent medical review panel shall be
3 a physician (allopathic or osteopathic) or health care
4 professional who—

5 “(A) is appropriately credentialed or li-
6 censed in 1 or more States to deliver health
7 care services; and

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

11 “(3) INDEPENDENCE.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), each member of the independent
14 medical review panel in a case shall—

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

17 “(ii) not have a material familial, fi-
18 nancial, or professional relationship with
19 such a party; and

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

23 “(B) EXCEPTION.—Nothing in subpara-
24 graph (A) shall be construed to—

1 “(i) prohibit an individual, solely on
2 the basis of affiliation with the plan or
3 issuer, from serving as a member of an
4 independent medical review panel if—

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

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

10 “(III) the fact of such an affili-
11 ation is disclosed to the plan or issuer
12 and the participant or beneficiary (or
13 authorized representative) and neither
14 party objects; and

15 “(IV) the affiliated individual is
16 not an employee of the plan or issuer
17 and does not provide services exclu-
18 sively or primarily to or on behalf of
19 the plan or issuer;

20 “(ii) prohibit an individual who has
21 staff privileges at the institution where the
22 treatment involved takes place from serv-
23 ing as a member of an independent med-
24 ical review panel merely on the basis of
25 such affiliation if the affiliation is disclosed

1 to the plan or issuer and the participant or
2 beneficiary (or authorized representative),
3 and neither party objects; or

4 “(iii) prohibit receipt of compensation
5 by a member of an independent medical re-
6 view panel from an entity if the compensa-
7 tion is provided consistent with paragraph
8 (6).

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

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

14 “(i) by a physician, the members of
15 an independent medical review panel shall
16 be practicing physicians (allopathic or os-
17 teopathic) of the same or similar specialty
18 as a physician who typically treats the con-
19 dition, makes the diagnosis, or provides the
20 type of treatment under review; or

21 “(ii) by a health care professional
22 (other than a physician), at least two of
23 the members of an independent medical re-
24 view panel shall be practicing physicians
25 (allopathic or osteopathic) of the same or

1 similar specialty as the health care profes-
2 sional who typically treats the condition,
3 makes the diagnosis, or provides the type
4 of treatment under review, and, if deter-
5 mined appropriate by the qualified external
6 review entity, the third member of such
7 panel shall be a practicing health care pro-
8 fessional (other than such a physician) of
9 such a same or similar specialty.

10 “(B) PRACTICING DEFINED.—For pur-
11 poses of this paragraph, the term ‘practicing’
12 means, with respect to an individual who is a
13 physician or other health care professional that
14 the individual provides health care services to
15 individual patients on average at least 2 days
16 per week.

17 “(5) PEDIATRIC EXPERTISE.—In the case of an
18 external review relating to a child, a member of an
19 independent medical review panel shall have exper-
20 tise under paragraph (2) in pediatrics.

21 “(6) LIMITATIONS ON REVIEWER COMPENSA-
22 TION.—Compensation provided by a qualified exter-
23 nal review entity to a member of an independent
24 medical review panel in connection with a review
25 under this section shall—

1 “(A) not exceed a reasonable level; and

2 “(B) not be contingent on the decision ren-
3 dered by the reviewer.

4 “(7) RELATED PARTY DEFINED.—For purposes
5 of this section, the term ‘related party’ means, with
6 respect to a denial of a claim under a plan or cov-
7 erage relating to a participant or beneficiary, any of
8 the following:

9 “(A) The plan, plan sponsor, or issuer in-
10 volved, or any fiduciary, officer, director, or em-
11 ployee of such plan, plan sponsor, or issuer.

12 “(B) The participant or beneficiary (or au-
13 thorized representative).

14 “(C) The health care professional that pro-
15 vides the items or services involved in the de-
16 nial.

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

20 “(E) The manufacturer of any drug or
21 other item that is included in the items or serv-
22 ices involved in the denial.

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

1 “(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

2 “(1) SELECTION OF QUALIFIED EXTERNAL RE-
3 VIEW ENTITIES.—

4 “(A) LIMITATION ON PLAN OR ISSUER SE-
5 LECTION.—The Secretary shall implement
6 procedures—

7 “(i) to assure that the selection proc-
8 ess among qualified external review entities
9 will not create any incentives for external
10 review entities to make a decision in a bi-
11 ased manner; and

12 “(ii) for auditing a sample of deci-
13 sions by such entities to assure that no
14 such decisions are made in a biased man-
15 ner.

16 “(B) STATE AUTHORITY WITH RESPECT
17 TO QUALIFIED EXTERNAL REVIEW ENTITIES
18 FOR HEALTH INSURANCE ISSUERS.—With re-
19 spect to health insurance issuers offering health
20 insurance coverage in a State, the State may
21 provide for external review activities to be con-
22 ducted by a qualified external appeal entity that
23 is designated by the State or that is selected by
24 the State in a manner determined by the State
25 to assure an unbiased determination.

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

8 “(3) TERMS AND CONDITIONS OF CONTRACT.—
9 The terms and conditions of a contract under para-
10 graph (2) shall—

11 “(A) be consistent with the standards the
12 Secretary shall establish to assure there is no
13 real or apparent conflict of interest in the con-
14 duct of external review activities; and

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

18 Subparagraph (B) shall not be construed as apply-
19 ing to the imposition of a filing fee under subsection
20 (b)(2)(A)(iv) or costs incurred by the participant or
21 beneficiary (or authorized representative) or treating
22 health care professional (if any) in support of the re-
23 view, including the provision of additional evidence
24 or information.

25 “(4) QUALIFICATIONS.—

1 “(A) IN GENERAL.—In this section, the
2 term ‘qualified external review entity’ means, in
3 relation to a plan or issuer, an entity that is
4 initially certified (and periodically recertified)
5 under subparagraph (C) as meeting the fol-
6 lowing requirements:

7 “(i) The entity has (directly or
8 through contracts or other arrangements)
9 sufficient medical, legal, and other exper-
10 tise and sufficient staffing to carry out du-
11 ties of a qualified external review entity
12 under this section on a timely basis, in-
13 cluding making determinations under sub-
14 section (b)(2)(A) and providing for inde-
15 pendent medical reviews under subsection
16 (d).

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

22 “(iii) The entity has provided assur-
23 ances that it will conduct external review
24 activities consistent with the applicable re-
25 quirements of this section and standards

1 specified in subparagraph (C), including
2 that it will not conduct any external review
3 activities in a case unless the independence
4 requirements of subparagraph (B) are met
5 with respect to the case.

6 “(iv) The entity has provided assur-
7 ances that it will provide information in a
8 timely manner under subparagraph (D).

9 “(v) The entity meets such other re-
10 quirements as the Secretary provides by
11 regulation.

12 “(B) INDEPENDENCE REQUIREMENTS.—

13 “(i) IN GENERAL.—Subject to clause
14 (ii), an entity meets the independence re-
15 quirements of this subparagraph with re-
16 spect to any case if the entity—

17 “(I) is not a related party (as de-
18 fined in subsection (g)(7));

19 “(II) does not have a material fa-
20 milial, financial, or professional rela-
21 tionship with such a party; and

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

1 “(ii) EXCEPTION FOR REASONABLE
2 COMPENSATION.—Nothing in clause (i)
3 shall be construed to prohibit receipt by a
4 qualified external review entity of com-
5 pensation from a plan or issuer for the
6 conduct of external review activities under
7 this section if the compensation is provided
8 consistent with clause (iii).

9 “(iii) LIMITATIONS ON ENTITY COM-
10 PENSATION.—Compensation provided by a
11 plan or issuer to a qualified external review
12 entity in connection with reviews under
13 this section shall—

14 “(I) not exceed a reasonable
15 level; and

16 “(II) not be contingent on any
17 decision rendered by the entity or by
18 any independent medical review panel.

19 “(C) CERTIFICATION AND RECERTIFI-
20 CATION PROCESS.—

21 “(i) IN GENERAL.—The initial certifi-
22 cation and recertification of a qualified ex-
23 ternal review entity shall be made—

1 “(I) under a process that is rec-
2 ognized or approved by the Secretary;
3 or

4 “(II) by a qualified private
5 standard-setting organization that is
6 approved by the Secretary under
7 clause (iii).

8 In taking action under subclause (I), the
9 Secretary shall give deference to entities
10 that are under contract with the Federal
11 Government or with an applicable State
12 authority to perform functions of the type
13 performed by qualified external review en-
14 tities.

15 “(ii) PROCESS.—The Secretary shall
16 not recognize or approve a process under
17 clause (i)(I) unless the process applies
18 standards (as promulgated in regulations)
19 that ensure that a qualified external review
20 entity—

21 “(I) will carry out (and has car-
22 ried out, in the case of recertification)
23 the responsibilities of such an entity
24 in accordance with this section, in-
25 cluding meeting applicable deadlines;

1 “(II) will meet (and has met, in
2 the case of recertification) appropriate
3 indicators of fiscal integrity;

4 “(III) will maintain (and has
5 maintained, in the case of recertifi-
6 cation) appropriate confidentiality
7 with respect to individually identifi-
8 able health information obtained in
9 the course of conducting external re-
10 view activities; and

11 “(IV) in the case recertification,
12 shall review the matters described in
13 clause (iv).

14 “(iii) APPROVAL OF QUALIFIED PRI-
15 VATE STANDARD-SETTING ORGANIZA-
16 TIONS.—For purposes of clause (i)(II), the
17 Secretary may approve a qualified private
18 standard-setting organization if such Sec-
19 retary finds that the organization only cer-
20 tifies (or recertifies) external review enti-
21 ties that meet at least the standards re-
22 quired for the certification (or recertifi-
23 cation) of external review entities under
24 clause (ii).

1 “(iv) CONSIDERATIONS IN RECERTIFI-
2 CATIONS.—In conducting recertifications of
3 a qualified external review entity under
4 this paragraph, the Secretary or organiza-
5 tion conducting the recertification shall re-
6 view compliance of the entity with the re-
7 quirements for conducting external review
8 activities under this section, including the
9 following:

10 “(I) Provision of information
11 under subparagraph (D).

12 “(II) Adherence to applicable
13 deadlines (both by the entity and by
14 independent medical review panels it
15 refers cases to).

16 “(III) Compliance with limita-
17 tions on compensation (with respect to
18 both the entity and independent med-
19 ical review panels it refers cases to).

20 “(IV) Compliance with applicable
21 independence requirements.

22 “(v) PERIOD OF CERTIFICATION OR
23 RECERTIFICATION.—A certification or re-
24 certification provided under this paragraph

1 shall extend for a period not to exceed 2
2 years.

3 “(vi) REVOCATION.—A certification or
4 recertification under this paragraph may
5 be revoked by the Secretary or by the or-
6 ganization providing such certification
7 upon a showing of cause.

8 “(D) PROVISION OF INFORMATION.—

9 “(i) IN GENERAL.—A qualified exter-
10 nal review entity shall provide to the Sec-
11 retary (or the State in the case of external
12 review activities provided for by a State
13 pursuant to paragraph (1)(B)), in such
14 manner and at such times as such Sec-
15 retary (or State) may require, such infor-
16 mation (relating to the denials which have
17 been referred to the entity for the conduct
18 of external review under this section) as
19 such Secretary (or State) determines ap-
20 propriate to assure compliance with the
21 independence and other requirements of
22 this section to monitor and assess the qual-
23 ity of its external review activities and lack
24 of bias in making determinations. Such in-
25 formation shall include information de-

1 scribed in clause (ii) but shall not include
2 individually identifiable medical informa-
3 tion.

4 “(ii) INFORMATION TO BE IN-
5 CLUDED.—The information described in
6 this subclause with respect to an entity is
7 as follows:

8 “(I) The number and types of de-
9 nials for which a request for review
10 has been received by the entity.

11 “(II) The disposition by the enti-
12 ty of such denials, including the num-
13 ber referred to an independent med-
14 ical review panel and the reasons for
15 such dispositions (including the appli-
16 cation of exclusions), on a plan or
17 issuer-specific basis and on a health
18 care specialty-specific basis.

19 “(III) The length of time in mak-
20 ing determinations with respect to
21 such denials.

22 “(IV) Updated information on
23 the information required to be sub-
24 mitted as a condition of certification

1 with respect to the entity’s perform-
2 ance of external review activities.

3 “(iii) INFORMATION TO BE PROVIDED
4 TO CERTIFYING ORGANIZATION.—

5 “(I) IN GENERAL.—In the case
6 of a qualified external review entity
7 which is certified (or recertified)
8 under this subsection by a qualified
9 private standard-setting organization,
10 at the request of the organization, the
11 entity shall provide the organization
12 with the information provided to the
13 Secretary under clause (i).

14 “(II) ADDITIONAL INFORMA-
15 TION.—Nothing in this subparagraph
16 shall be construed as preventing such
17 an organization from requiring addi-
18 tional information as a condition of
19 certification or recertification of an
20 entity.

21 “(iv) USE OF INFORMATION.—Infor-
22 mation provided under this subparagraph
23 may be used by the Secretary and qualified
24 private standard-setting organizations to
25 conduct oversight of qualified external re-

1 view entities, including recertification of
2 such entities, and shall be made available
3 to the public in an appropriate manner.

4 “(E) LIMITATION ON LIABILITY.—No
5 qualified external review entity having a con-
6 tract with a plan or issuer, and no person who
7 is employed by any such entity or who furnishes
8 professional services to such entity (including as
9 a member of an independent medical review
10 panel), shall be held, by reason of the perform-
11 ance of any duty, function, or activity required
12 or authorized pursuant to this section, to be
13 civilly liable under any law of the United States
14 or of any State (or political subdivision thereof)
15 if there was no actual malice or gross mis-
16 conduct in the performance of such duty, func-
17 tion, or activity.

18 **“SEC. 503E. EFFECT OF FEDERAL REVIEW STANDARDS FOR**
19 **GROUP HEALTH PLANS ON AVAILABILITY OF**
20 **LEGAL REMEDIES UNDER STATE LAW.**

21 “(a) IN GENERAL.—Subject to subsection (b), in the
22 case of any denial of a claim for benefits under a group
23 health plan with respect to which external review has been
24 completed under section 503D, nothing in section 503A,
25 503B, 503C, or 503D shall be construed to alter, amend,

1 modify, invalidate, impair, or supersede any provision of
2 State law (as defined in section 514(c)(1)) to the extent
3 that such provision provides a legal remedy for injury or
4 wrongful death resulting from such denial.

5 “(b) TREATMENT OF DELAYS BY EXTERNAL REVIEW
6 ENTITIES AND INDEPENDENT MEDICAL REVIEWERS.—
7 Notwithstanding subsection (a), this title supersedes any
8 provision of State law to the extent it provides for liability
9 for any violation of a timeline under section 503D applica-
10 ble to external review entities or independent medical re-
11 view panels (except with respect to any liability of any
12 such entity or any member of any such panel permitted
13 under section 503D(h)(4)(E)).

14 **“SEC. 503F. DEFINITIONS RELATING TO GROUP HEALTH**
15 **PLANS.**

16 “For purposes of this part—

17 “(1) GROUP HEALTH PLAN.—The term ‘group
18 health plan’ has the meaning given such term in sec-
19 tion 733(a), except that such term includes a em-
20 ployee welfare benefit plan treated as a group health
21 plan under section 732(d) or defined as such a plan
22 under section 607(1).

23 “(2) HEALTH CARE PROFESSIONAL.—The term
24 ‘health care professional’ means an individual who is
25 licensed, accredited, or certified under State law to

1 provide specified health care services and who is op-
2 erating within the scope of such licensure, accredita-
3 tion, or certification.

4 “(3) HEALTH CARE PROVIDER.—The term
5 ‘health care provider’ includes an allopathic or osteo-
6 pathic physician or other health care professional, as
7 well as an institutional or other facility or agency
8 that provides health care services and that is li-
9 censed, accredited, or certified to provide health care
10 items and services under applicable State law.

11 “(4) PARTICIPATING.—The term ‘participating’
12 means, with respect to a health care provider that
13 provides health care items and services to a partici-
14 pant or beneficiary under group health plan or
15 health insurance coverage offered by a health insur-
16 ance issuer, a health care provider that furnishes
17 such items and services under a contract or other
18 arrangement with the plan or issuer.

19 “(5) PRIOR AUTHORIZATION.—The term ‘prior
20 authorization’ means the process of obtaining prior
21 approval from a health insurance issuer or group
22 health plan for the provision or coverage of medical
23 services.

24 “(6) AUTHORIZED REPRESENTATIVE.—The
25 term ‘authorized representative’ means, with respect

1 to an individual who is a participant or beneficiary,
2 any health care professional or other person acting
3 on behalf of the individual with the individual's con-
4 sent or without such consent if the individual is
5 medically unable to provide such consent.

6 “(7) CLAIM FOR BENEFITS.—The term ‘claim
7 for benefits’ means any request for coverage (includ-
8 ing authorization of coverage), for eligibility, or for
9 payment in whole or in part, for an item or service
10 under a group health plan or health insurance cov-
11 erage.

12 “(8) DENIAL OF CLAIM FOR BENEFITS.—The
13 term ‘denial’ means, with respect to a claim for ben-
14 efits, a denial (in whole or in part) of, or a failure
15 to act on a timely basis upon, the claim for benefits
16 and includes a failure to provide benefits (including
17 items and services) required to be provided under
18 this title.

19 “(9) TREATING HEALTH CARE PROFES-
20 SIONAL.—The term ‘treating health care profes-
21 sional’ means, with respect to services to be provided
22 to a participant or beneficiary, a health care profes-
23 sional who is primarily responsible for delivering
24 those services to the participant or beneficiary.”.

25 (2) CONFORMING AMENDMENTS.—

1 (A) CAUSE OF ACTION TO COLLECT AS-
 2 SESSMENTS.—Section 502(a)(6) of such Act
 3 (29 U.S.C. 1132(a)(6)) is amended—

4 (i) by striking “or under” and insert-
 5 ing “, under”; and

6 (ii) by striking the period and insert-
 7 ing the following: “, or under section
 8 503D(f).”.

9 (B) SATISFACTION OF ERISA CLAIMS PRO-
 10 CEDURE REQUIREMENT.—Section 503 of such
 11 Act (29 U.S.C. 1133) is amended by inserting
 12 “(a)” after “SEC. 503.” and by adding at the
 13 end the following new subsection:

14 “(b) In the case of a group health plan (as defined
 15 in section 733) compliance with the requirements of sec-
 16 tions 503A through 503D in the case of a claims denial
 17 shall be deemed compliance with subsection (a) with re-
 18 spect to such claims denial.”.

19 (3) CLERICAL AMENDMENT.—The table of con-
 20 tents in section 1 of the Employee Retirement In-
 21 come Security Act of 1974 is amended by inserting
 22 after the item relating to section 503 the following:

“Sec. 503A. Utilization review activities.

“Sec. 503B. Procedures for initial claims for benefits and prior authorization determinations.

“Sec. 503C. Internal appeals of claims denials.

“Sec. 503D. Independent external appeals procedures.

“Sec. 503E. Effect of Federal review standards for group health plans on availability of legal remedies under State law.

“Sec. 503F. Definitions relating to group health plans.”.

1 (b) CONFORMING AMENDMENTS TO PUBLIC HEALTH
2 SERVICE ACT.—

3 (1) GROUP HEALTH PLANS.—Title XXVII of
4 the Public Health Service Act is amended by insert-
5 ing after section 2706 the following new section:

6 **“SEC. 2707. STANDARD RELATING TO ACCOUNTABILITY.**

7 “Subject to section 2724(c), a group health plan, and
8 health insurance coverage offered in connection with a
9 group health plan, shall comply with the requirements of
10 sections 503A through 503D of the Employee Retirement
11 Income Security Act of 1974 (as in effect as of the day
12 after the date of the enactment of such Act) and such re-
13 quirements shall be deemed to be incorporated into this
14 section. For purposes of this section, references in such
15 sections 503A through 503D to the Secretary shall be
16 deemed references to the Secretary of Health and Human
17 Services.”.

18 (2) INDIVIDUAL HEALTH PLANS.—Title XXVII
19 of the Public Health Service Act is amended by in-
20 sserting after section 2752 the following new section:

21 **“SEC. 2753. STANDARD RELATING TO ACCOUNTABILITY.**

22 “Subject to section 2762A(c), the provisions of sec-
23 tions 503A through 503D of the Employee Retirement In-
24 come Security Act of 1974 (as in effect as of the day after

1 the date of the enactment of such Act) shall apply to
2 health insurance coverage offered by a health insurance
3 issuer in the individual market for an enrollee in the same
4 manner as they apply to health insurance coverage offered
5 by a health insurance issuer for a participant or bene-
6 ficiary in connection with a group health plan in the small
7 or large group market and the requirements referred to
8 in such section shall be deemed to be incorporated into
9 this section. For purposes of this section, references in
10 such sections 503A through 503D to the Secretary shall
11 be deemed references to the Secretary of Health and
12 Human Services.”.

13 (c) CONFORMING AMENDMENTS TO THE INTERNAL
14 REVENUE CODE OF 1986.—Subchapter B of chapter 100
15 of the Internal Revenue Code of 1986 is amended—

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

“Sec. 9813. Standard relating to plan accountability.”;

19 and

20 (2) by inserting after section 9814 the fol-
21 lowing:

22 **“SEC. 9813. STANDARD RELATING TO PLAN ACCOUNT-**
23 **ABILITY.**

24 “A group health plan shall comply with the require-
25 ments of sections 503A through 503D of the Employee

1 Retirement Income Security Act of 1974 (as in effect as
2 of the day after the date of the enactment of such Act)
3 and such requirements shall be deemed to be incorporated
4 into this section. For purposes of this section, references
5 in such sections 503A through 503D to the Secretary shall
6 be deemed references to the Secretary of the Treasury.”.

7 **SEC. 3. STATE FLEXIBILITY IN APPLYING ACCOUNTABILITY**
8 **RULES TO HEALTH INSURANCE ISSUERS.**

9 (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT
10 INCOME SECURITY ACT OF 1974.—Part 5 of subtitle B
11 of title I of the Employee Retirement Income Security Act
12 of 1974 (as amended by section 2) is amended further—

13 (1) by redesignating section 503F as section
14 503G; and

15 (2) by inserting after section 503E the fol-
16 lowing new section:

17 **“SEC. 503F. STATE FLEXIBILITY IN APPLYING ACCOUNT-**
18 **ABILITY RULES TO HEALTH INSURANCE**
19 **ISSUERS.**

20 “(a) STATE FLEXIBILITY.—The requirements of sec-
21 tion 503A, 503B, 503C, or 503D shall not apply with re-
22 spect to health insurance coverage (and to a group health
23 plan insofar as it provides benefits in the form of health
24 insurance coverage) in a State—

25 “(1) before January 1, 2004; and

1 “(2) on or after such date, during any period
 2 for which the State certifies to the Patients’ Protec-
 3 tion Certification Board (established under sub-
 4 section (b)) that the State has in effect a State law
 5 (as defined in section 2723(d)(1) of the Public
 6 Health Service Act)—

7 “(A) that provides rules relating to consid-
 8 eration of claims for benefits or review of deni-
 9 als of such claims under such section 503A,
 10 503B, 503C, or 503D; and

11 “(B) that—

12 “(i) adopts the Federal rules under
 13 such section with respect to the consider-
 14 ation or review; or

15 “(ii) is consistent with the purposes of
 16 such section,

17 and the Board has not found such certification in-
 18 valid under subsection (b)(2)(A).

19 “(b) PATIENTS’ PROTECTION CERTIFICATION
 20 BOARD; CERTIFICATION REVIEW PROCESS.—

21 “(1) ESTABLISHMENT OF BOARD.—

22 “(A) IN GENERAL.—There is hereby estab-
 23 lished in the Health Resources and Services Ad-
 24 ministration of the Department of Health and
 25 Human Services a Patients’ Protection Certifi-

1 cation Board (in this section referred to as the
2 ‘Board’).

3 “(B) COMPOSITION.—The Board shall be
4 composed of 13 members appointed by the
5 President, by and with the advice and consent
6 of the Senate, from among individuals who rep-
7 resent consumers and employers or have exper-
8 tise in law, medicine, insurance, employee bene-
9 fits, and related fields. Members shall first be
10 appointed to the Board not earlier than Feb-
11 ruary 1, 2002, and no later than May 1, 2002.

12 “(C) TERMS.—The terms of members of
13 the Board shall be for 3 years except that for
14 the members first appointed the President shall
15 designate staggered terms of 3 years for 2
16 members, 2 years for 2 members, and 1 year
17 for one member. A vacancy in the Board shall
18 be filled in the same manner in which the origi-
19 nal appointment was made and a member ap-
20 pointed to fill a vacancy occurring before the
21 expiration of the term for which the member’s
22 predecessor was appointed shall be appointed
23 only for the remainder of that term.

24 “(D) COMPENSATION.—To the extent pro-
25 vided in advance in appropriations Acts, while

1 serving on the business of the Board (including
2 travel time), each member of the Board—

3 “(i) shall be entitled to receive com-
4 pensation at the daily equivalent of the an-
5 nual rate of basic pay provided for level IV
6 of the Executive Schedule under section
7 5315 of title 5, United States Code for
8 each day (including travel time) during
9 which the member is engaged in the actual
10 performance of duties as such a member;
11 and

12 “(ii) while so serving away from home
13 and the member’s regular place of busi-
14 ness, may be allowed travel expenses, as
15 authorized by the Board.

16 “(2) DUTIES.—

17 “(A) REVIEW OF CERTIFICATIONS SUB-
18 MITTED.—

19 “(i) IN GENERAL.—The Board shall
20 review certifications submitted under sub-
21 section (a)(2).

22 “(ii) DEFERENCE TO STATES.—Such
23 a certification submitted for a State law
24 with respect to the requirements of a sec-
25 tion is deemed valid unless, within 90 days

1 after the date of its submittal to the
2 Board, the Board finds that there is clear
3 and convincing evidence of substantial non-
4 compliance of the State law with the re-
5 quirements of subsection (a)(2)(B).

6 “(B) ANNUAL CONGRESSIONAL RE-
7 PORTS.—The Board shall submit to Congress
8 an annual report on its activities. The first an-
9 nual report shall focus specifically on the devel-
10 opment by the Board of criteria for the evalua-
11 tion of State laws and any other activities of
12 the Board during its first year of operation.

13 “(3) ORGANIZATION.—

14 “(A) CHAIR.—The Board shall elect a
15 member of the Board to serve as chair.

16 “(B) MEETINGS.—The Board shall meet
17 at least quarterly and otherwise at the call of
18 the chair or upon the written request of a ma-
19 jority of its members.

20 “(C) QUORUM.—Seven members of the
21 Board shall constitute a quorum thereof, but a
22 lesser number may hold hearings and take testi-
23 mony.

1 “(4) DIRECTOR AND STAFF; EXPERTS AND
2 CONSULTANTS.—To the extent provided in advance
3 in appropriations Acts, the Board may—

4 “(A) employ and fix the compensation of
5 an Executive Director and such other personnel
6 as may be necessary to carry out the Board’s
7 duties, without regard to the provisions of title
8 5, United States Code, governing appointments
9 in the competitive service;

10 “(B) procure temporary and intermittent
11 services under section 3109(b) of title 5, United
12 States Code; and

13 “(C) provide transportation and subsist-
14 ence for persons serving the Board without
15 compensation.

16 “(5) POWERS.—

17 “(A) OBTAINING OFFICIAL DATA.—

18 “(i) IN GENERAL.—The Board may
19 secure directly from any department or
20 agency of the United States information
21 necessary to enable it to carry out its du-
22 ties.

23 “(ii) REQUEST OF CHAIR.—Upon re-
24 quest of the chair, the head of that depart-
25 ment or agency shall furnish that informa-

1 tion to the Board on an agreed upon
2 schedule.

3 “(B) AGENCY ASSISTANCE.—The Board
4 may seek such assistance and support as may
5 be required in the performance of its duties
6 from the Secretary of Health and Human Serv-
7 ices, acting through the Health Resources and
8 Services Administration. Any employee of such
9 Administration may be detailed to the Board to
10 assist the Board in carrying out its duties.

11 “(C) CONTRACT AUTHORITY.—To the ex-
12 tent provided in advance in appropriations Acts,
13 the Board may enter into contracts or make
14 other arrangements for facilities and services as
15 may be necessary for the conduct of the work
16 of the Board (without regard to section 3709 of
17 the Revised Statutes (41 U.S.C. 5)).

18 “(D) HEARINGS.—The Board may, for the
19 purpose of carrying out its duties, hold hear-
20 ings, sit and act at times and places, take testi-
21 mony, and receive evidence as the Board con-
22 siders appropriate. The Board may administer
23 oaths or affirmations to witnesses appearing be-
24 fore it. To the extent provided in advance in ap-
25 propriation Acts, the Board may pay reasonable

1 travel expenses to witnesses for travel incident
2 to hearings held by the Board. Nothing in this
3 subsection shall be construed as authorizing the
4 issuance of subpoenas in support of its duties.

5 “(E) RULES.—The Board may prescribe
6 such rules and regulations as it deems nec-
7 essary to carry out this subsection.

8 “(6) AUTHORIZATION OF APPROPRIATIONS.—
9 There are authorized to be appropriated to carry out
10 this subsection—

11 “(A) for fiscal year 2002, \$500,000,

12 “(B) for fiscal year 2003, \$1,000,000, and

13 “(C) for subsequent fiscal years, such
14 sums as may be necessary.

15 “(c) RELATIONSHIP TO GROUP HEALTH PLAN RE-
16 QUIREMENTS.—Nothing in this section shall be construed
17 to affect or modify the provisions of section 514 with re-
18 spect to group health plans (insofar as they provide bene-
19 fits other than in the form of health insurance coverage).

20 “(d) CONFORMING REGULATIONS.—The Secretary
21 may issue regulations to coordinate the requirements on
22 group health plans under sections 503A through 503D
23 with the requirements imposed under the other provisions
24 of this title.”.

1 (2) CLERICAL AMENDMENT.—The table of con-
2 tents in section 1 of such Act (as amended by sec-
3 tion 2) is amended further—

4 (A) in the item relating to section 503F,
5 by striking “Sec. 503F.” and inserting “Sec.
6 503G.”; and

7 (B) by inserting after the item relating to
8 section 503E, the following:

 “Sec. 503F. State flexibility in applying accountability rules to health insurance
 issuers.”.

9 (b) STATE FLEXIBILITY IN APPLYING ACCOUNT-
10 ABILITY RULES UNDER THE PUBLIC HEALTH SERVICE
11 ACT.—

12 (1) GROUP HEALTH PLANS AND GROUP
13 HEALTH INSURANCE COVERAGE.—Title XXVII of
14 the Public Health Service Act is amended—

15 (A) in section 2723(a)(1) (42 U.S.C.
16 300gg–23(a)(1)), by inserting “and section
17 2724” after “Subject to paragraph (2)”; and

18 (B) by inserting after section 2723 the fol-
19 lowing new section:

20 **“SEC. 2724. STATE FLEXIBILITY IN APPLYING ACCOUNT-**
21 **ABILITY RULES.**

22 “(a) IN GENERAL.—The provisions of section 503F
23 of the Employee Retirement Income Security Act of 1974
24 apply with respect to the rules under section 2707 (only

1 as applied with respect to group health plans under section
2 2721(b)) in the same manner as such provisions apply to
3 comparable rules with respect to health insurance coverage
4 provided in connection with a group health plan.

5 “(b) RELATIONSHIP TO GROUP HEALTH PLAN RE-
6 QUIREMENTS.—Nothing in this section shall be construed
7 to affect or modify the provisions of section 514 of the
8 Employee Retirement Income Security Act of 1974 with
9 respect to group health plans (insofar as it provides bene-
10 fits other than in the form of health insurance coverage).”.

11 (2) INDIVIDUAL HEALTH INSURANCE COV-
12 ERAGE.—Title XXVII of the Public Health Service
13 Act is amended—

14 (A) in section 2762(a) (42 U.S.C. 300gg-
15 62(a)(1)), by inserting “and section 2762A”
16 after “Subject to subsection (b)”; and

17 (B) by inserting after section 2762 the fol-
18 lowing new section:

19 **“SEC. 2762A. STATE FLEXIBILITY IN APPLYING ACCOUNT-**
20 **ABILITY RULES.**

21 “The provisions of section 2724 apply in relation to
22 the rules under section 2755 (relating to accountability)
23 with respect to individual health insurance coverage in the
24 same manner as those provisions apply in relation to the

1 rules under section 2709, as applied to group health plans
2 under section 2721(b).”.

3 **SEC. 4. EFFECTIVE DATES AND RELATED RULES.**

4 (a) IN GENERAL.—The provisions of this Act, includ-
5 ing the amendments made by this Act, shall apply—

6 (1) to group health plans, and health insurance
7 coverage offered in connection with such plans, on
8 the later of—

9 (A) plan years beginning on or after Janu-
10 ary 1 of the first calendar year that begins
11 more than 1 year after the date of the enact-
12 ment of this Act; or

13 (B) plan years beginning on or after 18
14 months after the date on which the Secretary of
15 Health and Human Services and the Secretary
16 of Labor issue final regulations, subject to the
17 notice and comment period required under sub-
18 chapter 2 of chapter 5 of title 5, United States
19 Code, necessary to carry out such provisions
20 and the amendments made by this Act; and

21 (2) to individual health insurance coverage be-
22 ginning on or after the effective date described in
23 paragraph (1)(A).

24 (b) COVERAGE OF LIMITED SCOPE PLANS.—Section
25 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C.

1 300gg–91(c)(2)(A)) and section 733(c)(2)(A) of the Em-
2 ployee Retirement Income Security Act of 1974 (29
3 U.S.C. 1186(c)(2)(A)) shall be deemed not to apply for
4 purposes of applying the provisions of the amendments
5 made by this Act.

6 **SEC. 5. REGULATIONS; COORDINATION.**

7 (a) **AUTHORITY.**—The Secretaries of Health and
8 Human Services, Labor, and the Treasury shall issue such
9 regulations as may be necessary or appropriate to carry
10 out the amendments made by this Act before the effective
11 date thereof.

12 (b) **COORDINATION IN IMPLEMENTATION.**—The Sec-
13 retary of Labor, the Secretary of Health and Human Serv-
14 ices, and the Secretary of the Treasury shall ensure,
15 through the execution of an interagency memorandum of
16 understanding among such Secretaries, that—

17 (1) regulations, rulings, and interpretations
18 issued by such Secretaries relating to the same mat-
19 ter over which such Secretaries have responsibility
20 under the amendments made by this Act are admin-
21 istered so as to have the same effect at all times;
22 and

23 (2) coordination of policies relating to enforcing
24 the same requirements through such Secretaries in
25 order to have a coordinated enforcement strategy

1 that avoids duplication of enforcement efforts and
2 assigns priorities in enforcement.

3 (c) USE OF INTERIM FINAL RULES.—Such Secre-
4 taries may promulgate any interim final rules as the Sec-
5 retaries determine are appropriate to carry out this Act.

6 (d) LIMITATION ON ENFORCEMENT ACTIONS.—No
7 enforcement action shall be taken, pursuant to the amend-
8 ments made by this Act, against a group health plan or
9 health insurance issuer with respect to a violation of a re-
10 quirement imposed by such amendments before the date
11 of issuance of regulations issued in connection with such
12 requirement, if the plan or issuer has sought to comply
13 in good faith with such requirement.

14 **SEC. 6. NO BENEFIT REQUIREMENTS.**

15 Nothing in the amendments made by this Act shall
16 be construed to require a group health plan or a health
17 insurance issuer offering health insurance coverage to in-
18 clude specific items and services under the terms of such
19 a plan or coverage, other than those provided under the
20 terms and conditions of such plan or coverage.

21 **SEC. 7. SEVERABILITY.**

22 If any provision of this Act, an amendment made by
23 this Act, or the application of such provision or amend-
24 ment to any person or circumstance is held to be unconsti-
25 tutional, the remainder of this Act, the amendments made

1 by this Act, and the application of the provisions of such
2 to any person or circumstance shall not be affected there-
3 by.

○